Country WA PHN Activity Work Plan

Core Operational and Flexible

Summary View
2022/2023 – 2025/26

Presented to the Australian Government Department of Health and Aged Care

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Contents

CF 1000 - Managing Chronic Conditions

Activity Title

Managing Chronic Conditions

Activity Number

1000

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

Chronic disease is a major contributor to health burden in Australia and some people disadvantaged due to inequitable access to resources needed to address risk to health, have an increased susceptibility to adverse health outcomes, this includes Aboriginal people who experience higher risk of chronic health conditions

Clients living in rural Western Australia are generally unable to access multidisciplinary health care providers for the management of chronic conditions which hinders the effective management of their condition.

The Managing Chronic Conditions Program was developed to improve patient access to primary health care, provide coordinated care, reduce potentially preventable hospitalisations, and strengthen patient self-management for people with chronic conditions.

The chronic conditions targeted by this program include diabetes; respiratory conditions including Chronic Obstructive Pulmonary Disease (COPD) and asthma, obesity and cardiovascular conditions, such as Chronic Heart Failure (CHF).

The activity aims to continue to provide integrated primary health care services in areas where need has been demonstrated; determine the degree to which place based services for people with chronic conditions are making an impact on the health needs of the populations they serve with the support of core operational health systems improvement funding (activity HSI 1000 - Health System Improvement); and ensure that contracted service providers are meeting their contractual obligations.

Description of Activity

The Managing Chronic Conditions Program provides care coordination and nursing and allied health services, tailored to the needs of each of the seven (7) country health regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.

Chronic Disease Officers facilitate patient access to primary care services and integrate the chronic disease services provided by WA Country Health Service (WACHS) with Primary Health Network (PHN) funded community based primary health care services and other primary care providers, particularly general practitioners.

Services consist of:

- Multidisciplinary teams providing clinical and self-management support for vulnerable and disadvantaged persons with chronic diseases, with priority given to people with cardiovascular, diabetes and respiratory conditions.
- Care coordinators working to ensure patients are followed-up, receive the best wrap around care and are linked successfully with general practice and other appropriate health professionals.
- Culturally appropriate support and information to enable patients to work towards self-management of their condition.
- The use of evidence based self-management apps and other digital health technology in a patient's care plan to monitor their health and wellbeing. The model also includes group based self-management interventions.

The following PHN-wide services are available:

- Chronic Respiratory Disease and Diabetes Telehealth Services: these services work in partnership with local general practitioners and healthcare professionals to ensure continuity of care for patients. They provide one-on-one support/ consultations and education to support patient self-management in Country WA region via telephone and videoconferencing.
- Managing Chronic Conditions care coordination and allied health services across all seven Country WA PHN regions.
- Chronic Disease Officer services centrally and in all of the seven country regions.
- A Health Navigator service: this service, as part of the Managing Chronic Conditions model; the service uses phone and telehealth technology to support people with chronic conditions to develop a personal plan to enable them to effectively self-manage their chronic health conditions. The service is provided in the Great Southern, Wheatbelt and South West with possible expansion to other regions.

Concurrent to this activity, WAPHA recently developed an LGBTIQA+ Equity and Inclusion Framework committed to the development of a Cultural and Competency Framework and an Aboriginal Cultural Capability Framework, which encompass cultural awareness, cultural competency and cultural safety. A third Framework, focusing on multicultural competency, is in development, and will be launched in mid-2023.

These frameworks will facilitate opportunities to improve the cultural competence and clinical safety of services through continuous quality improvement and support programs. The frameworks will assist the PHN to reflect on current practice, identify areas that will improve cultural safety for communities, and develop cultural competence in internal staff and external stakeholders including commissioned services, resulting in better health and wellbeing outcomes for Aboriginal, CALD and LGBTQIA+ communities.

The above services integrate closely with the Integrated Team Care (ITC) program provided in all country regions, ensuring that primary health services that address chronic conditions are available to Aboriginal and Torres Strait Islander people throughout WA.

The PHN will continue to develop and maintain close working relationships with contracted service providers and will formally review services at six-and twelve-months intervals using a diverse range of data collection methods (i.e., provider reports, referral agency feedback, patient options) to determine:

- How well targeted and efficient services are.
- How effective services and systems are in relation to patient reported experience, patient reported health outcomes, service/system integration and service sustainability including provider experience/governance and service cost effectiveness.

A comprehensive review of all chronic conditions activities in the PHN is underway, due for completion in May 2023. This review will inform service planning for future chronic conditions services. Performance indicators for chronic condition services are also being implemented from 1 July 2023 along with improved frequency and depth of activity and outcome reporting.

The Country WA PHN signed an Agreement Protocol with the state health department WA Country Health Service to facilitate joint planning, priority setting and commissioning of integrated care to enhance health outcomes across Country WA PHN.

The PHN recognises the impact COVID-19 had on the community, primary health care and commissioned service activity. With services having returned, monitoring and

service impact assessment will continue, to ensure the PHN continues to meet the aims of the activity and the needs of the priority target groups.

Country WA PHN Needs Assessment

Priorities	Page reference
Support Primary Health Care providers to implement effective health interventions for those living with overweight and obesity.	71
Attract workforce who can provide Allied health services such as Podiatrist to manage chronic diseases.	71
Improve access to culturally appropriate services for Aboriginal people in the South West.	71
Investigate successful alternatives to the provision of primary care in Emergency Departments in country regions.	56
Ensure primary care services are available for people with chronic conditions that provide a holistic approach to management including improving self-management.	43
Improve access to coordinated culturally appropriate primary care for Aboriginal people.	151
Improve the self-management of heart disease especially chronic heart failure in Primary care.	15
Support primary care to promote healthy weight and healthy lifestyle changes.	15
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	15

Target Population Cohort

People with diabetes; respiratory conditions including Chronic Obstructive Pulmonary Disease (COPD) and asthma; obesity and cardiovascular conditions, such as Chronic Heart Failure, and who are not managing their condition/s.

Coverage

Country WA PHN

Activity Duration

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

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
Core Flexible	$11,175,768.07	$10,780,246.15	$10,897,890.09

CF 2000 - Developing System Capacity/Integration

Activity Title

Developing System Capacity/Integration

Activity Number

2000

Activity Status

Modified

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 primary health care services with access to a platform to support patient centred care through the extraction and analysis of primary care data.

Description of Activity

Initiatives delivered by the Primary Health Network (PHN) include:

<u>HealthPathways License and Support</u>

- The 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.

<u>My Community Directory</u>

- 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.

Commissioned Services Reporting Portal

- Building a digital portal that will collect a comprehensive common data set from Chronic Disease Providers and improve the accuracy, timeliness and quality of Chronic Disease performance data.
- Using the collected data to make data driven decisions that will provide better value for money commissioning and better manage provider performance.
- Providing performance dashboards to Chronic Disease providers to enable then to monitor and improve their own performance and deliver better value services in line with WAPHA's Performance Management Framework.
- Improve data security and governance for alcohol and other drug providers submitting performance data to WAPHA.
- Implementing, monitoring and evaluating standards and capabilities to ensure that commissioned services are effective and efficient and meet the needs of community.

Primary Care Reporting Portal

- Build an encrypted platform and validated access control enabling safe and secure method of delivery and access for all general practices sharing data.
- Providing real-time reporting of Practice information, Key reports and Insights.
- Providing performance dashboards to Practices enabling then to monitor and improve their own performance and deliver better value services.
- Enabling WAPHA to support general practices to engage in data informed quality improvement activities.

Primary Sense License

- The PHN is committed to empowering general practices by granting them access to Primary Sense, an advanced population health management, clinical decision support and data extraction tool. Through this initiative, all qualifying general practices will have the opportunity to leverage the power of Primary Sense to enhance their operational efficiency and clinical decision-making. To ensure that no practice is left behind, the PHN will provide grants to cover the license fee for data extraction for practices whose existing software does not integrate with Primary Sense. This proactive approach ensures that all practices that chose to share their data with the PHN, regardless of their current software

setup, can benefit from data analytics provided by WAPHA. This initiative demonstrates the PHN's unwavering commitment to supporting general practices and promoting the use of cutting-edge technology for better healthcare delivery. Primary Sense 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. Primary Sense aims to strengthen the capabilities of primary care providers and enhance patient care outcomes.

The PHN recognises the impact COVID-19 had on the community, primary health care and commissioned service activity. With services having returned, monitoring and service impact assessment will continue, to ensure the PHN continues to meet the aims of the activity and the needs of the priority target groups.

Country WA PHN Needs Assessment

Priorities	**Page reference**
Investigate successful alternatives to the provision of primary care in Emergency Departments in country regions.	56
Ensure primary care services are available for people with chronic conditions that provide a holistic approach to management including improving self-management. (Kimberley)	43

Coverage

Country WA PHN

Activity Duration

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

Activity Planned Expenditure

Funding Stream	**FY 22 23**	**FY 23 24**	**FY 24 25**
Core Flexible	$541,336.88	$315,196.32	$438,591.99

CF 2010 - PHN Clinical Referral Pathways

Activity Title

PHN Clinical Referral Pathways

Activity Number

2010

Activity Status

Modified

PHN Program Key Priority Area

Aged Care

Aim of Activity

This activity aims to develop and enhance clinical referral pathways on the HealthPathways platform relevant to the Primary Health Networks (PHN).

Activity outcomes will include enhanced linkages between primary health care services; other providers and relevant services; improvement to the patient journey and health outcomes, and increased practitioner capabilities and the quality of care provided.

Description of Activity

Clinical Referral Pathways will be developed, reviewed and enhanced as appropriate to the health needs of the Country WA PHN for use by clinicians during consultation with patients, supporting patient assessment and management, and referral to local services and supports.

This activity will:

- Increase the awareness, engagement, and utilisation of HealthPathways by primary care practitioners in the region.
- Increase awareness of and promote current best practice for the care of older adults.
- Enhance clinician awareness of and access to local referral options and services.
- Improve collaboration and integration across health care and other systems.

Clinical Referral Pathways development, enhancement, review and maintenance will include the following activities:

- Consultation with subject matter experts, peak bodies, and clinicians.
- Mapping and documentation of local support and referral services for the target population.
- Engaging with Streamliners NZ (who provide technical writing and editorial services) to publish Clinical Referral Pathways content.
- Monitoring, reviewing and improving existing Clinical Referral Pathways ensuring currency, accuracy and consistency with best practice.
- Identification of any information gaps in the Clinical Referral Pathways library and consideration of new pathway development or incorporation of information into existing pathway/s as required.
- Identification of relevant resources to include in the Clinical Referral Pathways for GPs and health professionals to share with patients.
- Promoting and delivering education where the need has been identified through a clinical referral pathway review or development.
- Maintain the license of the HealthPathways software and technical writing services provided by Streamliners NZ.

Target population

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

Country WA PHN Needs Assessment

Priorities	Page reference
Promote healthy ageing at home and reduce early entry into residential care. (Goldfields/Esperance)	15
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Goldfields, Midwest, Wheatbelt, South West)	15

Coverage

Country WA PHN

Consultation

Consultation will occur with the following key stakeholders:

- General practitioners and other primary health professionals.
- Consumer representatives or people with lived experience (if applicable to the

topic).

- Health Service Providers
- Older Adults Health Network
- WA Department of Health
- WA HealthPathways Users (accessible on request to WA based GPs and other AHPRA registered clinicians)
- Other PHN regions across Australia

The PHN promotes WA HealthPathways to specific audiences at conferences (e.g., Rural Health West Conference), through internally and externally produced written communications and articles (e.g., WAPHA publications GP Connect and Practice Connect; Medical Journal of Australia; Medical Forum).

The PHN delivers education and training to those working in general practice (and other clinicians) to:

- Provide an overview of the WA HealthPathways platform and its use.
- Launch new and newly reviewed HealthPathways, in conjunction with other PHN initiatives and in collaboration with subject matter experts, Health Service Providers and peak bodies (e.g., Dementia Care in General Practice).

Collaboration

Developing relationships and collaborating with key aged care stakeholders including peak bodies and provider organisations improves coordination, integration, and continuity of care at the aged care, health, primary care interfaces.

Key stakeholders, in addition to those listed above include:

- Royal Australian College of General Practitioners
- Subject Matter Experts, including hospital clinicians, non-GP medical specialists, allied health practitioners, nurses etc.), Consumer representatives, GPs, Health Service Providers, Peak Bodies (e.g., Diabetes WA, Trans, Gender Diverse and Non-Binary Health) to:
    - o Collaborate on clinical and referral pathways.
    - o Provide representation and specialist expertise in working groups related to HealthPathways development

- Streamliners NZ - The PHN administers the WA HealthPathways platform, which is owned by Streamliners NZ. The PHN develops and authors new clinical (and non-clinical) HealthPathways and Request (referral) pages and maintains and updating existing HealthPathways in line with the style guide provided by Streamliners. Streamliners provide technical writing services to standardise,

draft and publish the provided content to the WA HealthPathways platform.

- Other stakeholders as they are identified.

Activity Duration

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

Activity Planned Expenditure

Funding Stream	**FY 22 23**	**FY 23 24**	**FY 24 25**
HealthPathways	$272,700.00	$230,887.80	$234,120.23

CF 2011 - Aged Care Clinical Referral Pathways

Activity Title

Aged Care Clinical Referral Pathways

Activity Number

2011

Activity Status

Modified

PHN Program Key Priority Area

Aged Care

Aim of Activity

This activity will:

- Create, review and enhance the Primary Health Networks (PHN) HealthPathways content specific to aged care.
- Enhance linkages between primary health care services, other providers and relevant services.
- Improve the patient journey and health outcomes.
- Increase practitioner capabilities and the quality of care provided.

This activity aims to:

- Develop, review, enhance and maintain aged care clinical referral pathways (HealthPathways).
- Maintain the license of the HealthPathways software and technical writing services provided by Streamliners NZ.
- Increase the awareness, engagement, and utilisation of aged care HealthPathways by primary care practitioners in the region.
- Increase awareness of and promote current best practice for the care of older adults.
- Enhance clinician awareness of and access to local referral options and services.
- Improve collaboration and integration across health care and other systems.

Description of Activity

Aged care HealthPathways will be reviewed, enhanced and developed as appropriate to the health needs of the Country WA PHN for use by clinicians during consultation

with patients, supporting patient assessment and management, and referral to local services and supports.

Aged care HealthPathways development, enhancement, review and maintenance will include the following activities:

- Consultation with subject matter experts, peak bodies, and clinicians
- Mapping and documentation of local support and referral services.
- Engaging with Streamliners (who provide technical writing and editorial services) to publish HealthPathways content.
- Monitoring, reviewing and improving existing aged care clinical HealthPathways ensuring currency, accuracy and consistency with best practice.
- Identification of any information gaps in the HealthPathways library and consideration of new pathway development or incorporation of information into existing pathway/s as required.
- Identification of resources to include in HealthPathways for GPs and health professionals to share with patients.
- Promoting and delivering education related to the aged care HealthPathways.

Target population

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

Country WA PHN Needs Assessment

Priorities	Page reference
Promote healthy ageing at home and reduce early entry into residential care. (Goldfields/Esperance)	15
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Goldfields, Midwest, Wheatbelt, South West)	15

Coverage

Country WA PHN

Consultation

Consultation will occur with the following key stakeholders:

- General practitioners and other primary health professionals.

- Consumer representatives or people with lived experience (if applicable to the topic).
- Health Service Providers.
- Older Adults Health Network.
- WA Department of Health.
- WA HealthPathways Users (accessible on request to WA based GPs and other AHPRA registered clinicians).
- Other PHN regions across Australia

The PHN promotes WA HealthPathways to specific audiences at conferences (e.g., Rural Health West Conference), through internally and externally produced written communications and articles (e.g., WAPHA publications GP Connect and Practice Connect; Medical Journal of Australia; Medical Forum).

The PHN delivers education and training to those working in general practice (and other clinicians) to:

- Provide an overview of the WA HealthPathways platform and its use.
- Launch new and newly reviewed HealthPathways, in conjunction with other PHN initiatives and in collaboration with subject matter experts, Health Service Providers and peak bodies (e.g., Dementia Care in General Practice).

Collaboration

Developing relationships and collaborating with key aged care stakeholders including peak bodies and provider organisations improves coordination, integration, and continuity of care at the aged care, health, primary care interfaces.

Key stakeholders, in addition to those listed above include:

- Royal Australian College of General Practitioners
- Subject Matter Experts, including hospital clinicians, non-GP medical specialists, allied health practitioners, nurses etc.), Consumer representatives, GPs, Health Service Providers, Peak Bodies (e.g., Diabetes WA, Trans, Gender Diverse and Non-Binary Health) to:
    - o Collaborate on clinical and referral pathways.
    - o Provide representation and specialist expertise in working groups related to HealthPathways development
- Streamliners NZ – The PHN administers the WA HealthPathways platform, which is owned by Streamliners. The PHN develops and authors new clinical (and non-clinical) HealthPathways and Request (referral) pages and maintains and updating existing HealthPathways in line with the style guide provided by

Streamliners. Streamliners provide technical writing services to standardise, draft and publish the provided content to the WA HealthPathways platform.
- Other stakeholders as they are identified.

Activity Duration

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

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
HealthPathways	$72,720.00	$61,570.08	$62,432.06

CF 2012 - Dementia Support Pathways

Activity Title

Dementia Support Pathways

Activity Number

2012

Activity Status

Modified

PHN Program Key Priority Area

Aged Care

Aim of Activity

This activity will develop and enhance Primary Health Networks (PHN) HealthPathways content specific to dementia, enhance linkages between primary health care services; other providers and relevant services; improve the patient journey and health outcomes and increase practitioner capabilities and the quality of care provided.

This activity aims to:

- Develop, review, enhance and maintain relevant HealthPathways.
- Maintain the license of the HealthPathways software and technical writing services provided by Streamliners NZ.
- Increase the awareness, engagement, and utilisation of dementia HealthPathways by primary care practitioners in the region.
- Increase awareness of and promote current best practice for the care of patients with dementia.
- Enhance clinician awareness of and access to local referral options and services.
- Improve collaboration and integration across health care and other systems.

Description of Activity

Dementia support pathways will be reviewed, enhanced and developed as appropriate to the health needs of the Country WA PHN for use by clinicians during consultation with patients, supporting patient assessment and management, and referral to local services and supports.

Dementia support pathway development, enhancement, review and maintenance will include the following activities:

- Consultation with subject matter experts, peak bodies, and clinicians.
- Mapping and documentation of local support and referral services.
- Engaging with Streamliners NZ (who provide technical writing and editorial services) to publish HealthPathways content.
- Monitoring, reviewing and improving existing dementia support pathways ensuring currency, accuracy and consistency with best practice.
- Identification of any information gaps in the HealthPathways library and consideration of new pathway development or incorporation of information into existing pathway/s as required.
- Identification of resources to include in the clinical referral pathways for GPs and health professionals to share with patients.
- Promoting and delivering education related to the dementia support pathways.

Target population

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

Country WA PHN Needs Assessment

Priorities	Page reference
Promote healthy ageing at home and reduce early entry into residential care. (Goldfields/Esperance)	15
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Goldfields, Midwest, Wheatbelt, South West,)	15

Coverage

Country WA PHN

Consultation

Consultation will occur with the following key stakeholders:

- General practitioners and other health professionals
- Dementia Australia
- Dementia Australia WA
- Older Adults Health Network
- Alzheimer's WA
- Health Service Providers

- WA Department of Health
- WA HealthPathways Users (accessible on request to WA based GPs and other AHPRA registered clinicians)
- Consumer representatives and/or those with lived experience
- Other PHN regions across Australia

The PHN promotes WA HealthPathways to specific audiences at conferences (e.g., Rural Health West Conference), through internally and externally produced written communications and articles (e.g., WAPHA publications GP Connect and Practice Connect; Medical Journal of Australia; Medical Forum).

The PHN delivers education and training to those working in general practice (and beyond) to:

- Provide an overview of the WA HealthPathways platform and its use.
- Launch newly developed or reviewed clinical referral pathways, in conjunction with other PHN initiatives and in collaboration with SMEs, HSPs and peak bodies (e.g., Dementia Care in General Practice).

Collaboration

Developing relationships and collaborating with key aged care stakeholders including peak bodies and provider organisations improves coordination, integration, and continuity of care at the aged care, health, primary care interfaces.

Key stakeholders, in addition to those listed above include:

- Royal Australian College of General Practitioners
- Subject Matter Experts (SME) including hospital clinicians, non-GP medical specialists, allied health practitioners, nurses etc.), Consumer representatives, GPs, Health Service Providers, Peak Bodies (e.g., Dementia Australia) engage with HealthPathways WA to:
    - Collaborate on clinical and referral pathways.
    - Provide representation and specialist expertise in working groups related to HealthPathways development.
- Streamliners NZ - The PHN administers the WA HealthPathways platform, which is owned by Streamliners. The PHN develops and authors new clinical (and non-clinical) HealthPathways and Request (referral) pages and maintains and updating existing HealthPathways in line with the style guide provided by Streamliners NZ. Streamliners NZ provide technical writing services to standardise, draft and publish the provided content to the WA HealthPathways platform.
- Other stakeholders as they are identified.

Activity Duration

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

Key Milestones

- Dementia Support Services referral HealthPathway localisation (new development) published in October 2022.
- Dementia clinical HealthPathway review published in December 2022.
- Dementia education event for GPs and other primary care clinicians planned and scheduled for delivery in March 2023.

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
HealthPathways	$18,180.00	$15,392.52	$15,608.02

CF 2020 - Dementia Consumer Resources

Activity Title

Dementia Consumer Resources

Activity Number

2020

Activity Status

Modified

PHN Program Key Priority Area

Aged Care

Aim of Activity

The PHN will develop and maintain 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. This activity will be undertaken with input from Dementia Australia to ensure the Dementia Consumer Resources are both nationally consistent at a high level and reflective of individual services and supports within individual PHN regions. Further, this activity will be undertaken in conjunction with Dementia Support Pathways.

Description of Activity

Dementia Consumer Resources were developed and will be updated in collaboration with Dementia Australia to ensure the resources are both nationally consistent and reflective of individual services and supports within Country WA PHN.

A Dementia Consumer Resource was 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 promoted and available to those living with dementia and their family/carers.

This activity was 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 with further consultation and promotion of the resource during 23/24 and 24/25.

Dementia Consumer Pathway Resources were progressively implemented from 1 July 2022 and were in place by 1 January 2023 and included:

- 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 the Dementia Consumer Resources to ensure currency, accuracy and consistency with best practice and local services.
- Promoting the Dementia Consumer Resources to increase health professionals' awareness of current resources.
- Coordinating webinars targeted at health professionals to promote Dementia Consumer Pathway Resources.
- Ongoing marketing of Dementia Community Services and Support Finder during 2023/2024 https://www.mycommunitydirectory.com.au/Dynamic/dementia-wa

The Dementia Consumer Resources will be maintained and updated as necessary to ensure up to date information is available and reflect emerging best practice and appropriate services and supports within the region.

Target population

People living with dementia, their family and carers, GPs, health care staff in the Country WA PHN region

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Country WA PHN Needs Assessment

Priorities	**Page reference**
Investigate successful alternatives to the provision of primary care in Emergency Departments in country regions. (Midwest)	56
Ensure primary care services are available for people with chronic conditions that provide a holistic approach to management including improving self-management. (Kimberley)	43
Promote healthy ageing at home and reduce early entry into residential care. (Goldfields/Esperance)	15

Coverage

Country WA PHN

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:

- Consumer representatives
- GPs and other health professionals
- Dementia Australia
- Carers Australia
- Dementia Training Australia
- Dementia Support Australia
- Australian Dementia Network
- Alzheimer's WA.

Collaboration

Consultation will occur with key stakeholders and include:

- General practitioners and other health professional
- Dementia Australia
- Carers Australia
- Dementia Training Australia
- Dementia Support Australia
- Australia Dementia Network
- Alzheimer's WA
- Other stakeholders as they are identified

Activity Duration

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

Activity Planned Expenditure

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

CF 4000 - Healthy Weight

Activity Title

Healthy Weight

Activity Number

4000

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

To build knowledge, skills and confidence of primary healthcare professionals in the early detection and primary care interventions for chronic disease. This will be achieved through a targeted strategy to improve how overweight, and obesity are identified and addressed with patients through early intervention and management in general practice.

Early intervention and management pathways for overweight and obesity have been developed to support GPs and other primary health care professionals and their patients, with innovative, scalable, and sustainable approaches, programs, and tools for weight management.

Primary healthcare practitioners are encouraged to identify, engage, and regularly communicate with members of the multidisciplinary team in order to provide coordinated support for their patients with weight related health concerns. This includes dietitians, practice nurses, exercise physiologists and psychologists as well as evidence based and accessible healthy lifestyle programs.

The project encourages primary healthcare professionals to take a sensitive and supportive approach, free from weight stigma when communicating with patients about weight WA Primary Health Alliance will focus on creating sustainable behaviour change for general practitioners, other practice staff and allied health professionals and patients.
This work aligns to the WA Healthy Weight Action Plan, 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 includes 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:
    - Surveys conducted with general practitioners, practice nurses and allied health professionals working in general practice regarding gaps, barriers, and opportunities for better management of overweight and obesity in general practice.
    - Development of a practice toolkit for general practitioners including synthesis and applicability of current guidelines.
    - 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).
    - The use of Chronic Disease Management Plans via MBS for people with complex obesity, where clinically appropriate.
    - General practitioners and General Practitioner Registrar education regarding prevention, identification, and guidance of support options for people living with overweight and obesity. Awareness of the impact of weight bias, stigma and inequity is also addressed, and information is provided on how to reduce this in practice.
    - 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:
    - Up to date information on local programs and services for general practices.
    - Further development and promotion of HealthPathways, referral and management pathways for weight management for 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 events (informative and academic), focused on general practice continuous professional development (CPD) streams on sensitive conversations, empowering behaviour change, reducing

weight stigma 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 recognises the impact COVID-19 had on the community, primary health care and commissioned service activity. With services having returned, monitoring and service impact assessment will continue, to ensure the PHN continues to meet the aims of the activity and the needs of the priority target groups.

Target Population

WA Primary Healthcare Professionals (GPs, practice nurses, allied health professionals and general practice staff), who work with patients with weight related health issues and chronic conditions.

Country WA PHN Needs Assessment

Priorities	Page reference
Support primary care to promote healthy weight and healthy lifestyle changes. (Goldfields, South West, Wheatbelt)	15
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Goldfields, Midwest)	15

Indigenous Specific Comments

Stage 2 of the project will involve the development of resources to add to the existing website to assist healthcare professionals to support Aboriginal patients. This activity includes consultation with Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Healthcare workforce and general practice and consumer groups.

Coverage

Country WA PHN

Consultation

Phase 1 of the project consulted general practice clinicians, such as GPs, practice nurses, dietitians, and exercise physiologists to understand the barriers to weight management in general practice. The results of this consultation indicated that clinicians would benefit from evidence-based tools and resources in one accessible location.

The project convened a clinical content working group to contribute to guiding development of the clinical content and formulation of messaging for the branding campaign. The working group comprised General Practitioners, a psychologist, dietitians, the WA Department of Health and the Health Consumers' Council.

Stages 2 and 3 of the project includes the addition of material to support healthcare professionals to assist Aboriginal patients, people experiencing food insecurity and children with higher weight and their families. Consultation with a variety of stakeholders has commenced, to inform these additional project phases.

Development and maintenance of relationships with key stakeholders in the planning and delivery of the healthy weight related initiatives, has been ongoing throughout the duration of the project, including, but not limited to:

- WA Department of Health
- WA Health Consumers' Council
- WA Country Health Service
- Health Service Providers (i.e., East Metropolitan Health Service)
- WA General Practices
- Royal Australian College of General Practitioners WA
- Diabetes WA
- Cancer Council WA
- Aboriginal Community Controlled Health Organisations
- Child and Adolescent Health Service
- Curtin University

Collaboration

Stakeholders with direct involvement in the design and implementation of the project deliverables include, but are not limited to:

- WA Department of Health

- WA Health Consumers' Council
- WA Country Health Service
- Health Service Providers (i.e., East Metropolitan Health Service)
- WA General Practices
- Royal Australian College of General Practitioners WA
- Diabetes WA
- Cancer Council WA
- Aboriginal Community Controlled Health Organisations
- Child and Adolescent Health Service
- Curtin University

Activity Duration

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

Other Relevant Milestones

Stage 1 – Build infrastructure and develop resources (SHAPE website; launched in August 2022) to assist health care professionals to support patients aged 18-65 years with concerns related to weight and health. This stage is complete and supplementary activities are underway to raise awareness of SHAPE and these resources within primary health care and general practices.

Stage 2 – Develop and add resources to existing website to assist health care professionals to support patients living in Western Australia who identify as Aboriginal and Torres Strait Islander (Sept 2022 – June 2024).

Stage 3 – Add resources to existing website to assist health care professionals to support children and families living in Western Australia (Sept 2022 – 2025/TBC).

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
Core Flexible	$92,326.84	$57,427.00	$57,427.00

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

Activity Title

Strengthening general practice in WA: Comprehensive Primary Care

Activity Number

5000

Activity Status

New Activity

PHN Program Key Priority Area

Population Health

Aim of Activity

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

To build capacity, capability, and sustainability through collaboration with general practices in Country WA PHN and increase the overall health of communities to reduce potentially preventable hospitalisations.

The activity aims to develop sustainable general practice business models which increase access to comprehensive primary care services and reduce reliance on hospital emergency departments. The activity aims to increase access to skilled, integrated, multi-disciplinary teams which work to the top of their scope, increasing access to comprehensive health services including equity of access to after-hours care.

All activities are consistent with the foundations of the Comprehensive Primary Care (CPC) program based heavily on the Quintuple Aim of High Performing Practices. Building on this program our work will expand to a larger number of practices to integrate primary health services to address fragmentation, provide a seamless patient experience, and support effective communication and continuity of care across after hours service providers and a patient's regular general practitioner.

This activity will build capacity, capability, and sustainability through collaboration with Country general practices and increase the overall health of communities, reducing potentially preventable hospitalisations and non-urgent emergency department

presentations.

Description of Activity

This initiative focuses on working collaboratively to build capacity, capability, and sustainability of general practice to improve availability of general practitioner services. This will ensure a robust and continuous primary care system within country to support overall community health and reduce the reliance on hospital after hours services and potentially preventable hospitalisations.

An emphasis on collaboration with general practice, primary care services and allied health professionals addresses gaps in care to provide a seamless patient experience and reduce the impact of maldistribution of the workforce.

General practices will be supported to:

- Lead and develop practice teams which support the provision of sustainable primary care services in country, including access to after-hours care as appropriate.
- Improve their sustainability be adaptive to future changes and promote healthy communities to reduce reliance on hospitals, particularly after-hours and emergency services.
- Plan, collect, manage, and use data to optimise practice and business performance, and maximize patient health and population health outcomes with a focus on using data for quality improvement purposes, business viability, sustainability, and patient-centred care.
- Develop, and improve, sustainable quality improvement systems and processes to provide optimal health services in rural and regional WA.
- Ensure COVID-19 response activities, including supporting the management of chronic disease and screening initiatives.
- Improve the coordination and continuity of care to support patients and ensure better health and seamless primary care.
- Continuously improve business and clinical systems and processes to optimise the performance of the practice, using small, rapid cycles of quality improvement using the Plan Do Study Act model which has been demonstrated to have significant benefits against the Quintuple Aim.

Access leadership and change management training assistance with sustainable business models and financial modelling to support viable general practices thorough analysis of practice data to enable quality improvement activities with a view to sustainability including patient feedback; a regional community of practice – a support

network of other practices, to network, share lessons learned and best practice; training to support general practices in the use of clinical software programs.

The PHN recognises the impact COVID-19 had on the community, primary health care and commissioned service activity. With services having returned, monitoring and service impact assessment will continue, to ensure the PHN continues to meet the aims of the activity and the needs of the priority target groups.

Target population

People living with dementia, their family and carers, GPs, health care staff in the Country WA PHN region

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Country WA PHN Needs Assessment

Priorities	Page reference
Investigate successful alternatives to the provision of primary care in Emergency Departments in country regions. (Midwest)	56
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Goldfields, Midwest, Wheatbelt, South West,)	15
Promote healthy ageing at home and reduce early entry into residential care. (Goldfields/Esperance)	15

Coverage

Country WA PHN

Activity Duration

Activity Start Date	Activity End Date
1 January 2023	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
Core Flexible	$0.00	$200,000.00	$200,000.00

CF 6010 - GP Urgent Care Network Public Awareness and Education Campaign

Activity Title

GP Urgent Care Network Public Awareness and Education Campaign

Activity Number

6010

Activity Status

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

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Description of Activity

WA Primary Health Alliance partnered with the WA Department of Health (WADoH) to pilot a service to address behavioural change encouraging people to choose primary care over hospital options. The optimal urgent care model was 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.

The pilot ended in September 2021. The final Pilot report indicated that before additional investment is made in the GPUC Network model for the purposes of reducing ED demand, further research is needed to understand:

- GP capacity and whether it is possible to provide enough urgent care appointments to scale the program to a size where it can make a significant reduction in ED attendances.
- Reasons for the low conversion rate between landing page visits and GPUC appointments booked.
- How to improve the referral of calls from the 1800 Healthdirect helpline to GPUC practices.

In 2022 The Australian Government Department of Health and Aged Care committed to the establishment of 50 Urgent Care Clinics (UCCs) across all States and Territories, to deliver a new model of care to reduce pressure on hospital emergency departments (EDs). With varying levels of specificity (generally at the electorate level) announcements were also made about clinic locations.

In WA, the commitment for 7 UCC was for one in each of the following electorates: Perth, Hasluck, Forrest, Tangney, Moore, Brand, Durack. Consultation with the GPUCN is required to determine how both Urgent Care Services can co-exist and complement one another for optimal impact on emergency department demand.

As at 31 May 2023, 5 practices were participating in the GPUCN in the Country WA PHN. No new applications will be accepted while work is ongoing to establish the Medicare UCCs and gain an understanding of how both urgent care programs can co-exist and complement one another.

In collaboration with WA Health, updates are underway to streamline urgent care services within the National Health Service Directory. The National Health Service Directory is implementing a consistent approach for listing all urgent care services. The shared goal between WA Health and the National Health Service Directory is to ensure all services are listed as accurately as possible to guide people to the right level of care.

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. Appointments may 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.

Target population

General practitioners, practice nurses and other administration staff who manage the reception desk.
Population in general.

Priorities	Page reference
Investigate successful alternatives to the provision of primary care in Emergency Departments in country regions. (Midwest)	56

Coverage

Country WA PHN

Consultation

The PHN consulted with and continues to consult with a variety of stakeholders including:

- Hospital emergency department teams
- WA Health management
- GP Urgent Care network
- National Health Service Directory
- Health Direct

Consultation occurred with the GPUCN to understand the current capacity within the network and where the PHN can support practices to deliver Urgent Care services. The PHN are working in collaboration with WA Health to explore opportunities to link the GPUCN with ED Diversion activities and initiatives such as the Virtual Emergency Medicine service, strengthen relationships with Local hospitals and General Practices to promote the GPUCN and 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.

Key Milestones

Activity	Estimated timeline	Comment
Update to NHSD for all urgent care clinics	July 2023	Work is underway with the GPUCN to ensure practice details are correct and appear correctly in the urgent care filter. When searching for urgent care in the NHSD both the Medicare and GPUCN will be displayed, and patients can select the most suitable option for them.

Consultation with GPUCN on UCCs	April – Dec 2023	Initial workshop held in April 2023. Once UCCs are established in WA, WAPHA will continue to work with both Medicare UCCs and GPUCN and better understand how the services can complement one another. This may include a review of the number of GPUCN in areas with a Medicare UCC and the impact on patients presenting to a GPUCN practice. Funding may be better directed to support GPUCN practices in areas without a Medicare UCC.
Public awareness campaigns	Jan 2024	Any media campaigns to be developed in collaboration with WA Health and Department of Health and Aged Care to ensure consistency in messaging and streamlined. Considering practice level social media tools for promotion of the clinic's services to their local community.
Training for practice staff	Regular/Ongoing	Identified as an area of need and value at the GPUCN breakfast workshop in April. Plan to schedule clinical skills training regularly over the year. Training includes wound management, IV cannulation, ear syringing and suturing.

Activity Duration

Activity Start Date	Activity End Date
1 January 2023	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
Core Flexible	$0.00	$62,500.00	$62,500.00

CF-COVID-PCS 7000 - COVID-19 Primary Care Support

Activity Title

COVID-19 Primary Care Support

Activity Number

7000

Activity Status

Existing

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 Country WA Primary Health Network (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.

Country WA PHN Needs Assessment

Priorities	Page reference
Ensure Aboriginal people are accessing immunisations (i.e., Influenza) (Pilbara).	71
Ensure primary care services are available for people with chronic conditions that provide a holistic approach to management including improving self-management (Kimberley).	45
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields, Midwest, Wheatbelt, South West.)	15

Coverage

Country WA PHN

Activity Duration

Activity Start Date	Activity End Date
9 September 2021	31 December 2023

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
COVID-19 Primary Care Support	$717,188.00	$113,688.00	$0.00

CF-COVID-VVP 8000 - COVID-19 Vaccination of Vulnerable Populations

Activity Title

COVID-19 Vaccination of Vulnerable Populations

Activity Number

8000

Activity Status

Modified

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 Primary Health Network (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 practitioner 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 General Practitioners and health professionals.

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

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.

Country WA PHN Needs Assessment

Priorities	Page reference
Investigate successful alternatives to the provision of primary care in Emergency Departments in country regions (Midwest).	56
Improve access to culturally appropriate services for Aboriginal people in the South West.	71
Improve access to coordinated culturally appropriate primary care for Aboriginal people (Goldfields/Kimberley).	15

Coverage

Country WA PHN

Consultation

The PHN consulted with and continues to engage with a range of stakeholders in the planning and delivery of the Vulnerable Populations Vaccination Program, including but not limited to:

- General practice

- WA Department of Health
- WA Country Health Service
- Aboriginal Community Controlled Health Organisations
- Residential Aged Care Facilities
- First Nations COVID-19 Response Team
- Community Organisations

Collaboration

The PHN is working with the WA Department of Health, general practitioners, Community Organisations, Aboriginal Community Controlled Health Organisations and Residential Aged Care facilities to identify vulnerable people within their area, that have limited access to COVID-19 vaccination and information. These stakeholders will be directly involved in facilitating access to and administering COVID-19 vaccinations and information.

Activity Duration

Activity Start Date	Activity End Date
9 September 2021	31 December 2023

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
COVID-19 Vaccination of Vulnerable Populations	$555,986.08	$87,500.00	$0.00

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

Activity Title

Living with COVID-19 Positive Community Care Pathways

Activity Number

9010

Activity Status

Modified

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

The Primary Health Network (PHN) will work in partnership with WA Country Health Service, general practitioners (GPs) and the Aboriginal Community Controlled Health Sector (ACCHS) to develop or update COVID-19 positive community care pathways for Country WA PHN. 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 Practitioners 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.
- WAPHA place based staff will participate in the Country WA PHN's (seven health regions) COVID-19 emergency management forums, led by the WA Country Health Service as the Hazard Management Agency, to support the local COVID-19 response.
- 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.

In addition, information will be provided about resources and services that could assist with caring for COVID-19 positive people in the community

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Target population

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

Country WA PHN Needs Assessment

Priorities	**Page reference**
Improve access to culturally appropriate services for Aboriginal people in the South West.	71
Ensure primary care services are available for people with chronic conditions that provide a holistic approach to management including improving self-management (Kimberley).	43

Ensure integrated and stepped care services are available for people who experience mental health across the spectrum. (Kimberley, Midwest)	43
Improve access to coordinated culturally appropriate primary care for Aboriginal people. (Goldfields/Kimberley)	15

Coverage

Country WA PHN

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.

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

Activity Duration

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

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
Living with COVID-19	$113,213.16	$0.00	$0.00

CF-CV-LWC 9020 - Living with COVID-19 - 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

Activity Status

Existing

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) and Aboriginal Community Controlled Health Services (ACCHSs).

Description of Activity

The Primary Health Network (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. Available PPE 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-19 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.

Target population

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

Country WA PHN Needs Assessment

Priorities	Page reference
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields, Midwest, Wheatbelt, South West).	15

Coverage

Country WA PHN

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-19 initiatives, including:

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

Collaboration

The PHN is working with the Royal Australian College of General Practitioners WA, Australian Medical Association WA and Pharmacy Guild WA to ensure clear messaging and advice is provided to General Practitioners and Pharmacists regarding the provision of PPE via the NMS

Activity Duration

Activity Start Date	Activity End Date
1 March 2022	30 June 2023

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
Living with COVID-19	$202,703.29	$0.00	$0.00

CF-CV-LWC 9030 - Living with COVID-19 - Home Visiting Service

Activity Title

Living with COVID - Home Visiting Service

Activity Number

9030

Activity Status

Existing

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.

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-19 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

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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.

Country WA PHN Needs Assessment

Priorities	Page reference
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Goldfields, Midwest, Wheatbelt, South West,)	15
Investigate successful alternatives to the provision of primary care in Emergency Departments in country regions. (Midwest	56

Coverage

Country WA PHN

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

The PHN is working with:

- 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.
- 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 ACCHSs: ongoing through the establishment and implementation of service delivery, communication and escalation processes.

Activity Duration

Activity Start Date	Activity End Date
14 March 2022	30 June 2023

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
Living with COVID-19	$480,586.94	$0.00	$0.00

HSI 1000 - Health System Improvement

Activity Title

Health System Improvement

Activity Number

1000

Activity Status

Modified

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 North, Perth South 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.
- Progression of PHN priorities for action in response to Strengthening Medicare Taskforce recommendations and ongoing strategic leadership as a member of the Taskforce.
- 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 Quintuple Aim.

- Developing the cultural competence and capability of WAPHA and commissioned primary health care services to better meet the needs of priority communities. To facilitate cultural competence and capability, WAPHA has committed to the development of the Cultural and Competency Framework and an Aboriginal Cultural Capability Framework, which encompass cultural awareness, cultural competency and cultural safety. These frameworks will facilitate opportunities to improve the cultural competence and clinical safety of services through continuous quality improvement and support programs. The frameworks will assist the PHN to reflect on current practice, identify areas that will improve cultural safety for communities, and develop cultural competence in internal staff and external stakeholders including commissioned services, resulting in better health and wellbeing outcomes for Aboriginal, CALD and LGBTQIA+ 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 using digital health tools.
- Implementing programs leveraging Digital Health that are guided by the objectives of the Quintuple Aim and health priorities.
- Encouraging and influencing the use of specific digital health applications, such as My Health Record and Health Pathways WA.
- Assisting primary health care providers to understand and make meaningful use of digital health technology and collaborate with partners to pilot and innovate

in the delivery of quality health care services.

- Prioritising good data governance, security, privacy and consent principles that facilitate positive digital health outcomes.
- 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 primary care needs and priorities by triangulating multiple supply and demand data sets at a geographically granular level, integrating this with contextual local intelligence.
- Providing insights for activity planning based on health, demographic and workforce data, identifying potential geographical locations where limited resources can do the most good in collaboration with our external partners.
- Identifying priority populations to target for WAPHA's activities, including those experiencing economic disadvantage, Aboriginal people, CALD people, LGBTQI+ people, older people and other groups at risk of poor health outcomes or access barriers.

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.
- Working with commissioned primary health care services to improve cultural competence, capability, equity and inclusion of priority population groups including Aboriginal people, LGBTQIA+ and multicultural communities. This work will be facilitated with the Cultural and Competency Framework and an Aboriginal Cultural Capability Framework, currently under development by WAPHA.
- 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.
- 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.

The Country WA 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).

Target population

- People with, or at risk of, developing chronic and complex health issues. This includes mental disorders, problematic and harmful alcohol and drug use, chronic conditions and complex co-morbidities – for example, obesity and chronic heart failure.

- Communities experiencing enduring disadvantage This includes some older people, Aboriginal and Torres Strait Islanders, Culturally and Linguistically Diverse communities, LGBTQIA+ communities, people in poverty or deprivation, and socially and culturally marginalised groups.
- People at risk of developing significant health issues. This includes earlier intervention and management for people with co-existing chronic conditions and complex care needs in general practice, with emphasis on data driven quality improvement and research to identify innovative solutions to support prevention activities.
- Communities facing gaps in the health system This includes integrating primary health care, and our commissioned services, into the local health environment through effective partnerships. Utilising data informed assessments about health priorities to better address the needs of Western Australians.

Country WA PHN Needs Assessment

Priorities	Page reference
Ensure primary care services are available for people with chronic conditions that provide a holistic approach to management including improving self-management. (Kimberley)	43
Ensure integrated and stepped care services are available for people who experience mental health across the spectrum. (Kimberley, Midwest)	43
Improve access to coordinated culturally appropriate primary care for Aboriginal people. (Goldfields/Kimberley)	15
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Goldfields, Midwest, Wheatbelt, South West,)	15

Coverage

Country WA PHN

Consultation

The PHN utilises strategic partners, special interest panels, reference groups and targeted community consultation to inform the planning, design, delivery and monitoring of activities. Key stakeholders include commissioned service providers, peak bodies, primary care practitioners, state and local government, health service

providers, health professionals, consumers and people with lived experience.

Collaboration

The PHN's Member Organisations provide the Board with direct insight into the local primary care landscape and current operating environment, sharing priorities, strategies and progress in the delivery of health outcomes. They also share information on topics of mutual interest and work collaboratively to develop joint proposals and advocacy statements supporting our vision. Member organisations include the Royal Australian College of General Practitioners (WA), Rural Health West, WA Department of Health, Mental Health Commission WA, Western Australian Council of Social Service, Health Consumers' Council, Western Australian Local Government Association, Community Employers WA and the Australian College of Rural and Remote Medicine.

The PHN also has formal partnership arrangements in place to support coordination, collaboration and joint action on shared priorities with the:

- WA Mental Health Commission
- Australian Digital Health Agency
- Aboriginal Health Council of WA
- Health Service Providers

Activity Duration

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

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
Health System Improvement	$4,220,235.40	$3,628,604.78	$3,628,604.77

HSI 1010 - General Practice Support

Activity Title

General Practice Support

Activity Number

1010

Activity Status

Modified

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 Quintuple 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 e.g., general practitioners, practice managers, practice nurses, allied health practitioners 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 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 direct 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, Practice Connect Newsletter 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 and new information are also provided through these forums.
- Webinars and Community of Practice forums for general practitioners and other general practice staff around topical issues and priority subjects identified by the PHN and GPs.
- Informing and 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.

- Education on the use of HealthPathways to support clinical decision making by clinicians to increase positive patient outcomes.
- Inform, educate and support the use of digital health platforms, such as telehealth and ePrescribing, within practice to address access and equity of vulnerable patient cohorts.

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 quintuple health aims.

Data governance enhancements

Invest in improvements to WAPHA's data management capacity to protect the confidentiality, integrity and accessibility of information, guided by the ISO/IEC 27001 Standard. This will be achieved by:

- Funding a dedicated position within Business Services – Data Governance to lead the development of an ISO 27001 compliant Information Security Management System (ISMS). This includes enhanced definition of information management roles and responsibilities, information security risk assessment and treatment.
- Procurement of certification services and, as required, consultant support in the development of a compliant ISMS.

- Dedicated project management support to ensure best practice information management is embedded in organisational culture through appropriate governance, change management strategies, staff training and communications as part of the preparation for ISO 27001 certification and ongoing ISMS maintenance and improvement.
- Purchase of standards and of technology supports (e.g., risk management software) and other tools as determined necessary by the ISO 27001 Steering Committee to enable best practice Information Security Management practices.

Country WA PHN Needs Assessment

Priorities	Page reference
Increase Aboriginal childhood immunisation rates for regions not meeting national immunisation targets (Pilbara).	71
Improve the rates of cancer screening and reduce avoidable deaths from cancer (Kimberley).	43
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields, Midwest, Wheatbelt, South West).	15
Reduce non-urgent emergency department attendances and improve access to alternative services (Metro).	12

Coverage

Country WA PHN

Activity Duration

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

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
Health Systems Improvement	$397,802.75	$382,373.32	$382,373.32

HSI 1020 - HealthPathways

Activity Title

HealthPathways

Activity Number

1020

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

To develop (localise), maintain, promote and provide education on a comprehensive suite of WA specific HealthPathways which provide GP (and other health professionals) with best practice clinical guidance and local patient referral information. The result is patient care that is well coordinated, efficient and effective.

In Country WA, there is a specific focus on the incorporation of information into HealthPathways which is specific to rural and remote communities and supports the effective transition/referral of patients to regional and/or metropolitan specialists where necessary.

WA HealthPathways provides an opportunity for collaboration and integration between primary, secondary, and tertiary care including general practice, pharmacy, and allied health. This collaboration also contributes towards population health planning through the identification of service gaps.

WA HealthPathways support a multidisciplinary approach to patient care and provides information to GPs as the target audience but is also available to other healthcare professionals including general practice, pharmacy, and allied health. The WA HealthPathways team works collaboratively with Health Service Providers, the WA Department of Health, subject matter experts, HealthPathways team works collaboratively with Health Service Providers, the WA Department of Health, subject matter experts, peak bodies and consumers, in addition to general practice, to inform the resulting HealthPathways. This collaboration also contributes towards population health planning through the identification and escalation 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 coordinators and a leadership team. The team will develop and maintain content, raise awareness of and provide education to general practice about the product.

The main activities of the team include:

- Identifying, developing and authoring new clinical and (non-clinical) HealthPathways and Request (referral) pages.
- Reviewing and updating HealthPathways and the HealthPathways websites.
- Reviewing and incorporating best practice guidelines into new and existing pathways.
- Mapping services and incorporating them into new and existing pathways.
- Facilitating multi-disciplinary working groups.
- Facilitating pathway consultation in conjunction with WA Department of Health – Health Networks.
- Monitoring and evaluation uptake of the uptake of the tool.
- Demonstrating the use of resenting and providing education about HealthPathways.
- Facilitating promotion of HealthPathways.

PHN recognises the impact COVID-19 had on the community, primary health care and commissioned service activity. With services having returned, monitoring and service impact assessment will continue, to ensure the PHN continues to meet the aims of the activity and the needs of the priority target groups.

Target population

General practitioners are the primary audience of this activity, in addition to clinicians working in/supporting the provision of primary healthcare (i.e., practice nurses, allied health, pharmacy).

Country WA PHN Needs Assessment

Priorities	Page reference

Support primary care to promote healthy weight and healthy lifestyle changes (Goldfields)	18
Support Primary Health Care providers to implement effective health interventions for those living with overweight and obesity (Pilbara)	80
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Goldfields, Midwest, Wheatbelt, South West,)	18, 63, 95, 111
Improve the management of chronic conditions for ageing populations and ensure adequate service provision to promote healthy ageing at home (Great Southern, South West, Wheatbelt)	32, 95, 111

Coverage

Country WA PHN

Consultation

The PHN engages numerous stakeholders adhoc and ongoing to support progression of the WA HealthPathways Program including:

- WA Department of Health
- Health Service Providers
- WA HealthPathways Users

The PHN promotes WA HealthPathways to specific audiences at conferences (e.g., Rural Health West Conference), through internally and externally produced written communications and articles (e.g., WAPHA publications GP Connect and Practice Connect; Medical Journal of Australia; Medical Forum).

The PHN delivers education and training to those working in general practice (and other clinicians).

Collaboration

The PHN collaborates with the following stakeholders to support progression of the WA HealthPathways Program:

- Subject Matter Experts (SME)
  Including hospital clinicians, non-GP medical specialists, allied health practitioners, nurses practice (consumer representatives, general practitioners, Health Service Providers, Peak Bodies (e.g., Transfolk of WA) engage with HealthPathways WA to:

- Collaborate on clinical and referral pathways.
- Provide representation and specialist expertise in working groups related to HealthPathways development.

- Streamliners NZ
  The PHN administers the WA HealthPathways platform, which is owned by Streamliners NZ. The PHN develops and authors new clinical (and non-clinical) HealthPathways and Request (referral) pages and maintains and updating existing HealthPathways in line with the style guide provided by Streamliners NZ. Streamliners NZ provide technical writing services to standardise, draft and publish the provided content to the WA HealthPathways platform.

Activity Duration

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

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
Health Systems Improvement	$118,413.87	$112,960.09	$112,960.09

HSI 2000 - Stakeholder Engagement and Communication

Activity Title

Stakeholder Engagement and Communication

Activity Number

2000

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

Communications and stakeholder engagement activities aim to establish and nurture strong and meaningful purposeful 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.

Description of Activity

Communications and Marketing

The PHN will continue to communicate WAPHA's purpose and work by delivering high quality written and digital communications both internally and externally, to demonstrate impact, innovation and achievement.

This work is underpinned by:

- Strategic marketing and communications: develop the right message for the

right channel.

- Brand management: build and maintain a consistent corporate image.
- Media relations: facilitate favourable and timely media coverage.
- Government relations: support with visits and information requests.
- Issues Management: handle contentious issues/protect WAPHA's reputation.
- Internal communications: facilitate the delivery of interesting and important news and updates.

Priorities to 2025 include:

- Developing strategic key messages to align with the WA Primary Health Alliance Strategic Plan 2023 – 2026 targeting specific high interest/ high influence groups and used to educate our staff, Board and stakeholder networks to ensure we speak to our stakeholders consistently.
- Continuing 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 channels and methods which are most effective; and maintaining our online/ digital presence to ensure our voice is heard and that we are part of strategically important online conversations.
- Embedding culturally inclusive language and images across our platforms to demonstrate WAPHA's leadership in culturally safe and inclusive practice.

Stakeholder Engagement

The PHN will continue to:

- Lead and coordinate strategies, projects and activities that maintain the integrity of stakeholder engagement approaches across WAPHA.
- Build engagement capacity of staff and empower them to engage effectively with our stakeholders, including in use of digital platforms and enablers such as our stakeholder database and digital engagement platforms.
- Support projects and activities that uphold the cultural security of our stakeholder engagement approaches, ensure stakeholders are well informed and engaged in the development and implementation of our Reconciliation Action Plan and direct the work.
- Identify, facilitate and mature WAPHA's state-wide partnerships and support a strategic approach to the planning and delivery of local stakeholder engagement.

Priorities to 2025 include:

- Strengthening and embedding commissioning approaches and practices that work towards increasing the opportunities for a collaborative design approach to be applied.
- Increasing the ways in which community, consumers, family, and carers are

engaged across the commissioning cycle.

- Implementing the activities as outlined in the Stakeholder Engagement Framework Roadmap, with an emphasis on our digital enablers to engagement and evaluation of engagement practice and stakeholder sentiment to WAPHA.
- Further developing the WA GP Advisory Panel, in partnership with Rural Health West and the Royal Australian College of General Practitioners (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.
- Establishing Allied Health and Consumer Leader Panels to formalise engagement channels with key stakeholders.
- Maturing partnerships with strategic stakeholders.

The PHN recognises the impact COVID-19 had on the community, primary health care and commissioned service activity. With services having returned, monitoring and service impact assessment will continue, to ensure the PHN continues to meet the aims of the activity and the needs of the priority target groups.

Target population

General Practitioners are the primary audience of this activity, in addition to clinicians working in/supporting the provision of primary healthcare (i.e., practice nurses, allied health, pharmacy).

Country WA PHN Needs Assessment

Priorities	**Page reference**
Ensure primary care services are available for people with chronic conditions that provide a holistic approach to management including improving self-management. (Kimberley)	43
Improve access to coordinated culturally appropriate primary care for Aboriginal people. (Goldfields/Kimberley)	15
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Goldfields, Midwest, Wheatbelt, South West,)	15

Coverage

Country WA PHN

Consultation

WAPHA has drawn on the expertise of specialist reference groups of external stakeholders (Multicultural, LGBTIQA+ and Aboriginal) to inform communications and engagement planning and priorities.

Feedback from stakeholders on communications and engagement activities is used to inform continuous quality improvement to ensure content, channels and activities are meeting the needs of stakeholders.

Collaboration

The WA GP Advisory Panel has been established as a partnership with Royal Australian College of General Practitioners WA and Rural Health West. The Royal Australian College of General Practitioners WA make an in kind contribution by administering payment to GPs, and all partners play an equal role in setting agendas and actioning comments raised by members

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Activity Duration

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

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
Health Systems Improvement	$422,292.67	$200,586.91	$200,586.91

END