Perth North PHN Activity Work Plan

Core Operational and Flexible

Summary View
2022/2023 – 2025/2026

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 health burden in Australia. Vulnerable and disadvantaged people are at higher risk of chronic health conditions

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

- Areas where need has been demonstrated.
- 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).

The Primary Health Network (PHN) will continue to work to structure supply in order to increase access to primary health services for people with chronic conditions; support self-management; sustain engagement with general practitioners and other primary health professionals and develop the capacity of the primary health workforce.

Description of Activity

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

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

effective care in the community and reduced hospital admissions. The service recruit's patients from eight metropolitan hospitals.

2. COPD Community Care – the service works in collaboration with the Silver Chain COPD Supported Discharge service, to provide community support and education to individuals with COPD, recently discharged from hospital due to a COPD related admission. The service supports clients to engage with primary care including facilitated connection to general practice, with the aim of establishing more effective care in the community and reduced hospital admissions.
3. Primary Care at Home -the service provides primary health care to people at risk of poor health outcomes and difficulty accessing appropriate services vulnerable and disadvantaged people who are currently engaged with community and social services. The service takes healthcare into the homes of some of Perth's more vulnerable people, whether that be a house, hostel, or community residential facility. The service provides health assessment, treatment, development of an individualized care plan and connection to a general practitioner.
4. Street Doctor is a mobile general practitioner clinic offering a bulk billed health service that aims to improve patient health outcomes and reduce hospitalisation for marginalised people of all ages. StreetDoctor provides the services of a conventional practice. A doctor and a nurse staff the service, with outreach workers and a mental health outreach worker providing support to those accessing the clinic services. The clinic operates on a drop in/walk in basis from five different locations covering the CBD and eastern metropolitan region of Perth. Other commissioned services may be considered that support the needs and health issues of the target group.
5. Persistent Pain Program – the program aims to help persistent pain sufferers improve self-management of their pain through expert education, individual case management, support, goal setting and improved use of community healthcare services. The program also aims to build the capacity of the primary health sector in identified locations to provide improved chronic pain management. The program is designed so that participants can explore a range of different strategies for living well leading to:
    - reduced reliance on medication for pain management
    - reduced requirements for emergency care
    - participants not requiring referral to a higher level of hospital-based care.

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

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

Using the new WA Primary Health Alliance Performance Management Framework (PMF), the PHN will measure and track providers performance against specified PMF indicators relating to health equity patient reported experiences, patient reported outcomes and service cost effectiveness. The PHN will use the data to evaluate the performance of services and inform any necessary actions.

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.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Reduce non-urgent emergency department attendances and improve access to alternative services. (Metro)	12
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home. (Metro)	41

Target Population Cohort

People who require primary care and who may be vulnerable or require additional support to manage their chronic condition

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Coverage

Perth North 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	$1,817,854.63	$1,861,285.42	$1,845,604.79

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.

Perth North PHN Needs Assessment

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

Coverage

Perth North 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	$684,866.25	$380,420.73	$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 will:

- Develop, maintain, and enhance clinical referral pathways (HealthPathways) content relevant to the Primary Health Network (PHN).
- 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 relevant and prioritised HealthPathways.
- Maintain the license of the HealthPathways software and technical writing services provided by Streamliners NZ.

  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.

Description of Activity

Clinical Referral Pathways will be developed, reviewed, and enhanced as appropriate to the health needs of the Perth North 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 general practitioners 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.

Perth North PHN Needs Assessment

Priorities	Page reference
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11

Support the mental health of older people and assist primary care providers to identify older people who may need additional support or referrals to services. (Metro)	18
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home. (Metro)	41
Promote early intervention and monitoring activities to support older adults to live at home and reduce early entry into residential care. (Metro)	41
Support people living with dementia and their carers to navigate the aged care system and access appropriate services. (Metro)	41

Coverage

Perth North 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
- 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, general practitioners, 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 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:

- Develop 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 Perth North 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 general practitioners 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.

Perth North PHN Needs Assessment

Priorities	Page reference
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home. (Metro)	41
Promote early intervention and monitoring activities to support older adults to live at home and reduce early entry into residential care. (Metro)	41
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	11

Coverage

Perth North 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).
- Older Adults Health Network.
- Council on the Ageing
- Health Service Providers
- WA Department of Health.
- WA HealthPathways Users (accessible on request to WA based GPs and other AHPRA registered clinicians).

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, general practitioners, 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 Perth North 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 general practitioners 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.

Perth North PHN Needs Assessment

Priorities	Page reference
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home. (Metro)	41
Promote early intervention and monitoring activities to support older adults to live at home and reduce early entry into residential care. (Metro)	41
Support people living with dementia and their carers to navigate the aged care system and access appropriate services. (Metro)	41

Coverage

Perth North 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, general practitioners, 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 general practitioners 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 Perth North 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 for further information.

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, general practitioners, health care staff in the Perth North PHN region.

Perth North PHN Needs Assessment

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

Coverage

Perth North 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
- General practitioners 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 general practitioners 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 (general practitioners, practice nurses, allied health professionals and general practice staff), who work with patients with weight related health issues and chronic conditions.

Perth North PHN Needs Assessment

Priorities	Page reference
Support Primary Health Care providers to implement effective health interventions for those living with overweight and obesity.	11
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	11

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 and Torres Strait Islander patients. This activity includes consultation with Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Healthcare workforce and general practice and consumer groups.

Coverage

Perth North PHN

Consultation

Phase 1 of the project consulted general practice clinicians, such as general practitioners, 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

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	$93,069.14	$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

Modified

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.

This activity aims to strengthen and improve the primary care response and access to general practice using the foundations of the Comprehensive Primary care (CPC) program, based on the Quintuple Aim of the Patients Centred Medical Home, and using Bodenheimer Building Blocks. The activities will use data driven quality improvements, focusing on enhanced leadership, team-based care and patient management responding to their needs, for example:

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

provides support to patients to self-manage.

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

Description of Activity

Perth North PHN will continue to deliver two key initiatives under this activity –

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

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

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

General practices will be supported to:

- Lead and develop practice teams to successfully undertake an evidence based and staged process to undertake practice transformation using QI processes.
- Improve continuity of care with allied health, tertiary and secondary services through integrated models of multidisciplinary team-based care, data sharing, integrated care plans and specialist in-reach programs.
- Have an opportunity to influence, co-design and trial general practitioner led models of care and incorporate existing local services that:
    - are integrated, place based and supported by a multi-disciplinary team.
    - are tailored to meet the needs of individual practices and patients.
    - build on existing and/or introduce new and innovative models of care that reflect national and international best practice.
    - are scalable, sustainable, and adaptive to future changes.

    - improve coordination and continuity of care to ensure better health and social outcomes for patients.
    - build practices' capacity and capability to deliver responsive patient centred care, which empowers patients to be informed and engaged in the management of their own health care.
- Have access to a Community of Practice – a support network of other practices, to network, share lessons learned and best practice; leadership and change management training and development activities; business education, training and support for optimising practice systems, revenue, productivity, efficiency, and overall performance of the business; training to support general practices in the use of clinical software programs.
- The PHN will deliver COVID-19 response activities and support the management of chronic disease and screening initiatives.

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, general practitioners, health care staff in the Perth North PHN region.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Reduce non-urgent emergency department attendances and improve access to alternative services. (Metro)	12
Improve the rates of cancer screening and reduce avoidable deaths from cancer. (Metro)	11
Increase childhood immunisation rates for regions not meeting national immunisation targets. (Metro)	11
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11

Coverage

Perth North 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	$0.00	$191,410.38	$189,105.11

CF 5050 - PHN Collaborative Data and Analytics Centre of Excellence

Activity Title

PHN Collaborative Data and Analytics Centre of Excellence

Activity Number

5050

Activity Status

Modified

PHN Program Key Priority Area

Other - Data and Analytics, Health System Improvement

Aim of Activity

The aim of this activity is to:

- Bolster the primary care data analytics capability across all Primary Health Networks (PHN) by establishing centralised data and analytics quality and management standards and frameworks.
- Build on the existing investment in Primary Health Insights and enhance PHNs' ability to leverage the platform to deliver consistent and collaborative analytics and reports.
- Enhance PHNs' ability to generate insights, deliver national policy agendas, and plan and evaluate value-based care initiatives locally, regionally, and nationally.

Description of Activity

Funded Activity Scope

WA Primary Health Alliance, as Lead PHN for Primary Health Insights (PHI), will:

- Research and maintain knowledge of current and future technology trends that support data quality, security, management, and analytics.
- Develop data and analytics models on service utilisation, activity modelling and other aspects of PHN services which inform government decisions about resource allocation.
- Develop uniform data and reporting standards and frameworks for PHNs' performance reporting and analysis which then enables bench marking across the network.
- Lead communities of practice across PHNs and enable peer collaboration on

analysing primary healthcare data which supports the sharing and update of health care innovations and improvements across the network.

Managed and delivered within the Primary Health Insights Services team, a detailed Work Plan that identifies and prioritises key needs, gaps and opportunities in PHN data and analytics will be developed and maintained. This detailed Work Plan will be approved by a Steering Committee with a Department of Health and Aged Care delegate as a decision maker, while operational governance and oversight will be incorporated into the existing PHI governance structure.

WAPHA will work collaboratively with other PHNs to resource and staff individual projects and activities within the detailed Work Plan, as a way of ensuring that any increased capability or capacity generated through upskilling and knowledge acquisition remains within the network.

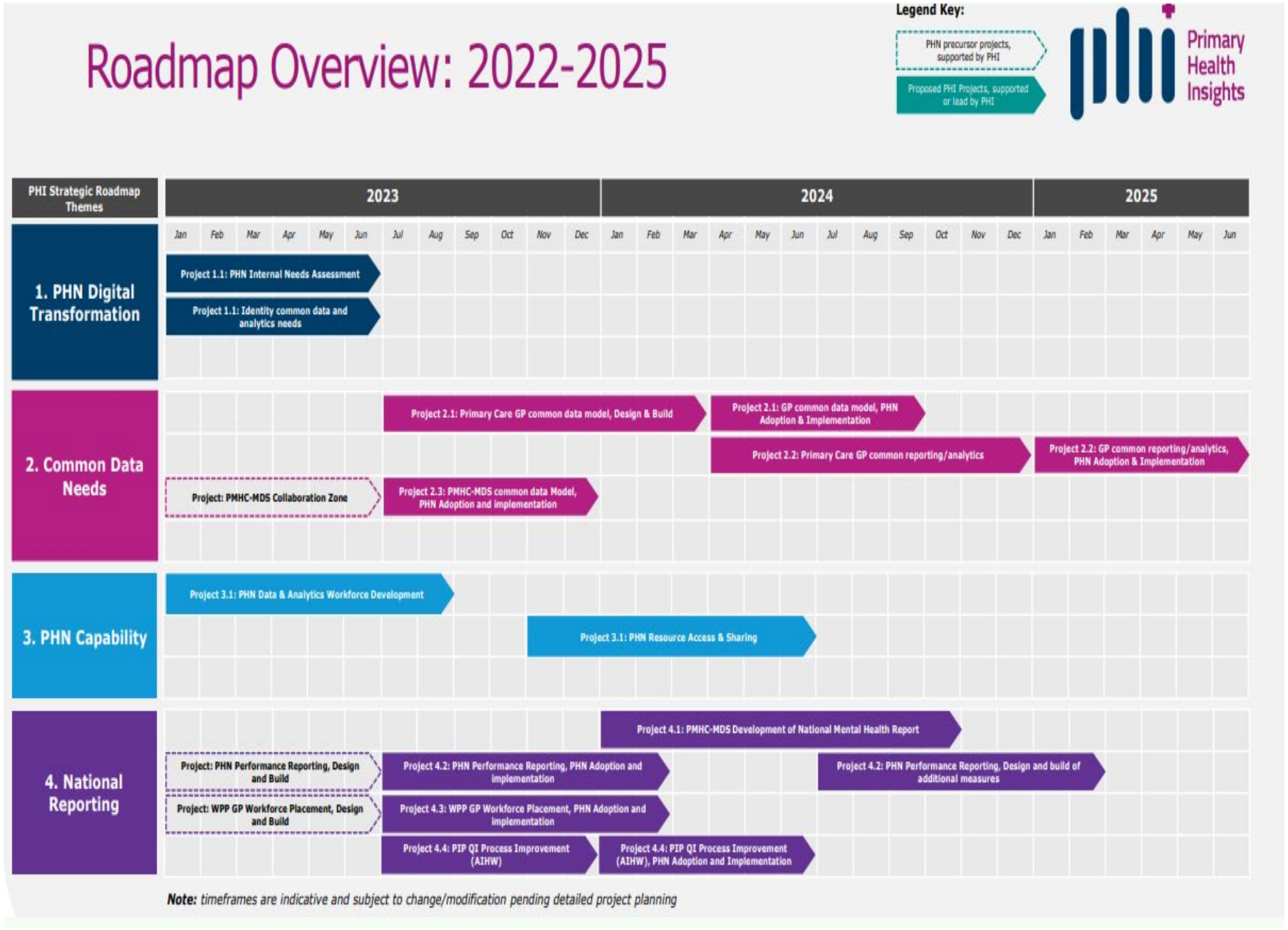
The following outputs are expected to be delivered as an outcome of this activity:

- New or improved tools and systems within PHI that enable more, easier, and quicker collaboration among PHN data and analytics staff.
- Standard data models for common sources or types of data (e.g., GP data, aged care data) that can be created and used by and across PHNs independent of the source systems or technologies used.
- Standard algorithms and analytics processes for common business needs that can be easily adopted and adapted by and across PHNs.
- Standard reporting and visualisation formats and templates for common requirements that enable data consumers (e.g., the Department of health and Aged Care) to more quickly, easily, and accurately aggregate data provided by PHNs at regional and national levels.
- Increased data and analytics capability and capacity within all PHNs through reduced effort required to deliver common requirements, increased skills and process maturity, and a greater ability for PHNs to resource and process sharing across PHNs.

Work Plan Overview

The Work Plan provided to the Steering Committee that covers WAPHA's responsibilities under this Activity identified the following new projects to be funded and delivered during FY23 and FY24 (noting that not all projects have yet been identified for FY25):

Roadmap Overview: 2022-2025



Note: *timeframes are indicative and subject to change/modification pending detailed project planning*

Project/Activity	Description
Project 1.1 - PHN Workforce and Common Data & Analytics Needs Analysis	Extensively engage with PHNs to undertake the first-ever comprehensive collection and analysis of a) the PHN data & analytics workforce, and b) current data & analytics tasks and gaps. The desired outcomes include standardised job requirements and skill descriptions, and a prioritised list of data & analytics tasks that are similar enough across all PHNs to easily be replaced with a common standardised process. **Status:** Commenced, but start was delayed due to waiting for new national PHN governance structures to be established to coordinate national-level activities.
Project 2.1 – Primary Care GP common data model, design, and build	There currently up to 31 different ways in which PHNs process general practice data for analysis and reporting. Many PHNs may be reporting on the same metrics or reporting to the same standards (PIP QI, RACGP 5th standard for accreditation) but in different ways. The intended outcome of this project is a single data model that can be populated by PHNs using any GP data source or extraction tool, and then used as a common basis for developing further standardised analytics scripts or reports. **Status:** Scheduled to commence early in FY 24
Project 2.2 – Primary Care GP common reporting & analytics	Using the newly developed common GP data model (from Project 2.1), this project will develop a series of standard reports and analytical scripts that all PHNs can use to address common needs sourced in this dataset. This will include quality improvement, population health analysis, health needs assessment, and other PHN reporting. Note that this project will support but not replicate work being undertaken by WentWest (Western Sydney PHN) to develop a single national shared GP dataset for single-point-of-truth national reporting and analysis but will focus instead on the reporting and analytical work that must take place within each PHN. **Status:** Scheduled to commence late in FY 24
Project 2.3 – PHMC-MDS Collaboration Zone	Currently there is no standardised process for storing, analysing, and reporting on the primary mental health care -minimum data set (PMHC-MDS) data across PHNs. This project leverages the first PHI Collaboration Zone for the pooling and analysis of Primary Mental Health Care

	Minimum Data Set (PMHC-MDS) data from up to 12 PHNs to identify and standardise ways to generate improved insights when PHNs can have non-aggregated data, and develop standard data models, analytics scripts, and report templates to facilitate this. **Status:** Commenced and underway
Project 3.1 – PHN Data & Analytics Workforce Development / Sharing	PHNs have varying degrees of data & analytical skillsets and team structures. There is a growing need to align staff skillsets and knowledge with PHI technology. As PHI continues to grow and expand, the skillsets and knowledge of PHNs should also grow with it. PHNs require some direction as to what the future workforce would look like to inform recruitment and professional development, and to enable PHNs to better identify and share these skills with each other. This project will develop role-based learning and development pathways, recommended minimum skill sets against common data & analytics role types, and a national PHN staff and skills directory. **Status:** Commenced and underway
Project 4.1 – Develop PHMC-MDS National Mental Health Report	Using the newly developed common PHMC-MDS data model (from Project 2.3), this project aims to support PHNs to develop a new "national report card" based on this data and do so in a way that will establish process, policy and agreement standards that can be leveraged by future projects to develop similar national-level reports based on other PHN priority service delivery areas. **Status:** Scheduled to commence in mid-FY24
Project 4.2 – PHN Performance Reporting	The current process undertaken by PHNs to collect and report on performance data to Department of Health and Aged Care through PPERS as part of the AWP process is manual, cumbersome, and does not enable the Department of Health and Aged Care to do any useful analytics, comparisons, or reporting. This project will deliver a new national platform to collect, collate, approve, submit and report on statistical performance data from all PHNs for the Department of Health and Aged Care, as well as work with PHNs and the Department of Health and Aged Care to expand the metric set to be reported and simplify and improve the Department of Health and Aged Care ability to access and use this information. **Status:** Commenced and underway

Project 4.3 – WPP General Practice Workforce Placement	PHNs are now responsible for developing needs assessments to inform the placement of Commonwealth-funded GP trainee positions under the Workforce Planning and Prioritisation (WPP) service. This project is intended to develop and support a process and platform to facilitate this activity. **Status:** Commenced but on hold pending clarification of larger WPP program scope
Project 4.4 – AIHW PIP QI Reporting Process Improvement	Currently PHNs are requested to submit their quarterly PIP eligible dataset (based on data collated from individual GP PIP QI submissions) via an Excel file template which is then uploaded to the Australian Institute of Health & Welfare (AIHW) Portal. Whilst AIHW provides a technical reporting specification to PHNs, there is still a considerable amount of data cleansing and validation required both before and after the file is submitted to AIHW. This project will develop a more consistent and streamlined process for PHNs to prepare the PIP submission files and provide improved quality to AIHW. **Status:** Commenced and underway

Perth North PHN Needs Assessment

Priorities	**Page reference**
Reduce non-urgent emergency department attendances and improve access to alternative services. (Metro)	12
CGP1.5 Promote the effectiveness of digital health technologies to optimise patient care (telehealth).	106
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11

Coverage

Funded through Perth North PHN, and delivered Statewide and nationally

Consultation

WAPHA has will continue to consult broadly in supporting PHNs to use and enhance the PHI platform to deliver improved data and analytics capabilities. Key stakeholders that will be engaged in the development and implementation of the detailed Work Plan include:

1. Department of Health and Aged Care – Engaged in the development and review of the purpose and role of this funding, the Department of Health and Aged Care will continue oversight through the Steering Committee on an at-least-quarterly basis in approving, reviewing, and updating the detailed Work Plan and progress against it.
2. Australian Institute of Health & Welfare – As the national data custodian for a range of data collections such as PIP QI, AIHW will be engaged to inform, support, and give feedback on any data and analytics improvement activity under the detailed Work Plan that relates to its functions. WAPHA as Lead PHN has been engaging with the AIHW to help identify areas for improvements since late 2020.
3. PHN Cooperative – As part of developing a PHI Strategic Plan, WAPHA engaged with all PHNs through both a national workshop in August 2022 and provision of a Consultation Draft Strategic Plan, which included (but was not limited to) the activity to be funded through the CoE within its scope. This enabled PHNs to examine the proposed work within its larger context alongside existing PHI work. In addition, PHNs have established a new national cross-PHN governance framework under a Primary Health Transformation Coordination
4. Primary Health Transformation Coordination Committee (PHTCC)- To help ensure that national projects support and do not conflict with each other.

Collaboration

WAPHA is delivering the outputs and outcomes of this Activity as a Lead PHN working with other stakeholders, particularly other PHNs:

- Primary Health Networks – both consultations to identify and prioritise needs, but also engagement and participation of staff from other PHNs in planning and developing the solutions to meet those needs. PHNs engagement includes governance and broad community of practice involvement.
- Department of Health and Aged Care - Key staff within the Department of Health and Aged Care have been engaged as key consumers of PHN data and analytics products to ensure that PHN data submissions can more effectively support national policy agendas and programs.
- Australian Institute of Health & Welfare – As a key stakeholder in the PIP QI process, the AIHW is being engaged as a collaborator in developing improved approaches for PIP QI submission, as well as other projects where capability and capacity exist.

Milestones

Establish Steering Committee and hold inaugural meeting by 30 May 2022
Detailed work plan for 2022-23 by 30 July 2022

Detailed work plan for 2023-24 by 30 June 2023
Detailed work plan for 2024-25 by 30 June 2024

Activity Duration

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

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
PHN Collaborative Data and Analytic Centre of Excellence	$2,457,00.00	$987,000.00	$840,000.00

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:

- General practitioner 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. 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, 29 practices were participating in the GPUCN in the Perth North 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.
WA Health's 'Is ED where you need to be' campaign directs patients to the GPUCN as an alternative care pathway, the PHN will continue to develop and adapt public awareness campaigns to complement and clearly define the differences between the GPUCN and Medicare UCCs.

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.

Perth North PHN Needs Assessment

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

Coverage

Perth North 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 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	Once UCCs are established in WA, the PHN will continue to work with both Medicare UCCs and GPUCN to better understand how the services can complement one another.
Public awareness	Jan 2024	Media campaigns developed in

campaigns		collaboration with WA Health and Department of Health and Aged to ensure consistency in messaging and streamlined. Consider practice level social media tools for promotion of the clinic's services to their local community.
Training for practice staff	Regular/Ongoing	Clinical skills training regularly over the year. Training to include 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	$150,000.00	$125,000.00

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

Activity Title

COVID-19 Primary Care Support

Activity Number

7000

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

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

Perth North PHN Needs Assessment

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

Target Population Cohort

Primary health, aged care, and disability sectors

Coverage

Perth North 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	$982,813.00	$154,688.00	$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 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.

Indigenous Specific Comments

With lower COVID-19 vaccination rates than that of the general population, this sector will continue to be the focus of the Vulnerable Populations Vaccination Program. To support this, engagement with General practice, Aboriginal Community Controlled Health Organisations (ACCHOs), community and non-government organisations and state health will continue.

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.

Perth North PHN Needs Assessment

Priorities	Page reference
Reduce non-urgent emergency department attendances and improve access to alternative services. (Metro)	12
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro	11
People living at home or in RACFs need support to manage conditions to prevent escalating acuity. (Metro)	41

Coverage

Perth North 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
- Aboriginal Community Controlled Health Organisations
- Residential Aged Care Facilities
- Community Organisations
- Commissioned Services
- Local Government
- Education Institutions
- Peak Bodies

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 and education institutions to identify vulnerable people within their area, which 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	$663,813.76	$134,531.00	$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 Health Service Providers, general practitioners (GPs) and the Aboriginal Community Controlled Health Sector (ACCHS) to develop or update COVID-19 positive community care pathways for Perth North 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 a doctor admits the patient to receive care delivered by a hospital) and where the patient does not require admission GP-led care in the community.
- Information will be provided about resources and services that could assist with caring for COVID-19 positive people in the community.
- Development, ongoing review, and maintenance of a number of comprehensive Statewide localised HealthPathways for the assessment, management, and treatment of COVID-19 positive patients, in line with National, State and Royal Australian College of General Practitioner guidelines.
- 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.

Target population

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

Perth North PHN Needs Assessment

Priorities	Page reference
People living at home or in RACFs need support to manage conditions to prevent escalating acuity. (Metro)	41
Increase utilisation of the GP aged care MBS items to provide GP care to aged care residents. (Metro)	41

Coverage

Perth North 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

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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.

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	$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-19 Support for Primary Care from the National Medical Stockpile

Activity Number

9020

Activity Status

Modified

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.

Perth North PHN Needs Assessment

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

Coverage

Perth North 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 February 2020	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

Modified

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

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

Description of Activity

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

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

The Home Visiting Service will be undertaken by suitably qualified and experienced staff, and the interaction between the Home Visit Service staff and general practitioners (and other relevant service providers, such as pharmacists, providers of residential aged care facility / congregate living services) will be based on established communication and escalation processes.

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

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

Indigenous Specific Comments

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

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.

Perth North PHN Needs Assessment

Priorities	Page reference
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	11
Reduce non-urgent emergency department attendances and improve access to alternative services. (Metro)	12
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home. (Metro)	41

Coverage

Perth North 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.
- Residential aged care facilities/Mental Health Hostels: 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	$629,740.43	$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 Department of Health and Aged Care 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 Department 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 Perth North 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.

Perth North PHN Needs Assessment

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

Coverage

Perth North 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	$3,742,392.43	$2,738,671.70	$2,738,671.70

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 the Department of Health and Aged Care 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 initiative-taking 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 general practitioners.
- 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.

- Utilising various modalities including face to face sessions, small group sessions and use of online/technology-based resources such as webinars and special interest groups (e.g., Project ECHO).
- 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 the PHN 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.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Reduce non-urgent emergency department attendances and improve access to alternative services. (Metro)	12
Improve the rates of cancer screening and reduce avoidable deaths from cancer. (Metro)	11
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11
Increase Aboriginal childhood immunisation rates for regions not meeting national immunisation targets. (Metro)	34

Coverage

Perth North 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	$642,613.00	$435,128.38	$435,128.38

HSI 1020 - HealthPathways

Activity Title

HealthPathways

Activity Number

1020

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

To develop and localise, maintain, promote, and provide education on a comprehensive suite of WA specific HealthPathways which provide general practitioners 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.

WA HealthPathways support a multidisciplinary approach to patient care and provides information to general practitioners 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 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).

Perth North PHN Needs Assessment

Priorities	Page reference
Promote integration and coordinated care pathways for clients with mental health condition and harmful alcohol and other drug use. (Metro)	27
Support Primary Health Care providers to implement effective health interventions for those living with overweight and obesity. (Metro)	11
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11
Support the mental health of older people and assist primary care providers to identify older people who may need additional support or referrals to services. (Metro)	18

Improve coordinated and integrated care for people experiencing complex and severe mental health who can be managed in within primary care settings. (Metro)	18
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home. (Metro)	41
Support people living with dementia and their carers to navigate the aged care system and access appropriate services. (Metro)	41
Support primary health care providers to provide culturally appropriate chronic disease management for Aboriginal populations and build capacity for patient self-management. (Metro)	34

Coverage

Perth North 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	$224,514.61	$138,986.19	$138.986.19

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

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).

Perth North PHN Needs Assessment

Priorities	Page reference
Reduce non-urgent emergency department attendances and improve access to alternative services. (Metro	12
Promote integration and coordinated care pathways for clients with mental health condition and harmful alcohol and other drug use. (Metro)	27
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11

Coverage

Perth North 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 general practitioners, and all partners play an equal role in setting agendas and actioning comments raised by members.

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	$454,331.64	$246,802.31	$246,802.31

END