Perth North PHN Activity Work Plan

Aged Care Program

Summary View
2023/2024 – 2026/2027

Presented to the Australian Government Department of Health and Aged Care

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Contents

AC-VARACF 1000 - Support RACF's to increase availability and use of telehealth care for aged care residents

Activity Title

Support RACF's to increase availability and use of telehealth care for aged care residents

Activity Number

1000

Activity Status

Modified

PHN Program Key Priority Area

Aged Care

Aim of Activity

In response to the Royal Commission into Aged Care Quality and Safety, the Australian Government has funded Primary Health Networks (PHNs) to undertake dedicated activities which support better health, wellbeing and access to primary care and aged care services for senior Australians.

Timely access to primary health care professionals, whether through face-to-face consultation or via telehealth is recognised as an issue for many RACFs, and at times this can lead to potentially preventable hospitalisations. The Supporting RACFs to increase availability and use of telehealth care for aged care residents' (RACF Telehealth) initiative aims to improve access to health care and reduce residents' avoidable and unnecessary hospitalisations.

The RACF Telehealth initiative supports participating RACFs in the Perth North Primary Health Network (PNPHN) region to have appropriate virtual consultation abilities and technology so their residents can access timely health care (with a particular focus on primary health and aged care) via telehealth, and where possible avoid preventable hospitalisation.

PNPHN will:

- Assist participating RACFs in the PHN region, to offer telehealth facilities and have equipment to enable residents to virtually consult with primary health care professionals.

- Provide training to participating RACF staff so they have the capabilities to assist residents in accessing virtual consultation services.
- Promote the use of enablers of digital health, such as My Health Record (MyHR) to improve the availability and secure transfer of resident's health care information between the RACF, primary care and acute care settings.
- Consult with key stakeholders to improve technological interoperability between the aged care and health care systems.

Description of Activity

The GEN Aged Care Data Service list identifies 103 RACFs in PNPHN at 30 June 2023.

On 30 June 2019, PNPHN had a higher rate of residential aged care recipients per 1000 target population (41%) compared to the state (38%) (AIHW, 2020e) with 89% residential care occupancy rate. Many residents have complex health conditions, atypical symptoms, and multiple comorbidities. Their health can deteriorate rapidly. More than half (55%) of people using permanent residential aged care in the PHN had a diagnosis of dementia. Ref: PNPHN Needs Assessment 2022-2024.

Rationale

Western Australian GPs have told the WA Primary Health Alliance (WAPHA) of multifactored issues that serve as barriers to working in the RACF context, such as the time it takes to travel to and from the facility and the lost earning opportunity, and challenges with parking at or close to the facility.

Telehealth can:

- Address barriers to providing and accessing high quality healthcare in RACFs.
- Provide access to services that may not be available locally.
- Preventing the need for residents to travel.
- Avoiding the negative impacts of removing residents from their home environment for avoidable hospital visits.
- Assist in reducing the exposure of residents to communicable diseases and infections in EDs.

Roles and Responsibilities

WAPHA's Primary Care Innovation and Development Portfolio, which works across the three WA PHNs, is responsible for the delivery of the RACF Telehealth initiative. An executive sub-committee oversees all PNPHN aged care activity including the RACF Telehealth initiative to ensure it aligns with funding requirements and guidance, and WAPHA's Strategic Plan 2023-2026.

A small team, consisting of an activity lead and Digital Health Officers lead the RACF

Telehealth activities across the three WA PHNs. Contract management, place-based integration managers, and training and practice support staff assist the team. A program logic guides activities.

Key activities

WAPHA commissioned Visionflex to deploy telehealth carts and provide training to RACFs that have expressed an interest in securing the equipment. The equipment bundle includes clinical equipment which allows GPs and other health professionals to monitor residents' vital signs, wounds, and skin conditions.

Porth 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

Target Population Cohort

This activity will focus on RACFs located in the PHN region, particularly those that participate in the initiative, and
health professionals, particularly primary healthcare professionals, that provide services within the PHN.

Coverage

Perth North PHN

Consultation

- Royal Australian College of GPs (WA)
- Residential Aged Care Facilities
- Aged and Community Care Providers Association representatives.
- General Practitioners
- WA Department of Health Aged and Community Policy Team
- Department of Health and Aged Care WA Stewardship Team
- WA Health Virtual Emergency Department
- East Metropolitan Health Service (EMHS) Community Health in a Virtual Environment (Co-HIVE) Aged Care Service
- North Metropolitan Health Service (NMHS) Emergency Care Navigation Centre (ECNC).

Collaboration

PNPHN will invite RACFs to participate in RACF Telehealth activities.

As part of the initiative participating RACFs will identify Telehealth Champions to work with other RACF staff to increase telehealth capability and to trouble shoot any issues.

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department as agreed	100%
The number of participating RACFs in the PHN region and the number which have had their virtual access capability services assessed	100%
The number of participating RACFs in the PHN region which have the appropriate facilities and equipment to access service virtually	100%
A brief description of the training and support the PHN has provided to RACF staff or practitioners in relation to virtual access services	100%

Activity Milestone	Due Date
Activity Work Plan and Budget	30 April 2024, 30 April 2025
Twelve-month Performance Report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025
Needs Assessment	15 November 2024

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Virtual Access in RACFs	$1,018,409.10	$0.00	$0.00

AC-AHARACF 2000 - Enhanced After Hours Support for Residential Aged Care Facilities

Activity Title

Enhanced After Hours Support for Residential Aged Care Facilities

Activity Number

2000

Activity Status

Modified

PHN Program Key Priority Area

Aged Care

Aim of Activity

In response to the Royal Commission into Aged Care Quality and Safety, the Australian Government has funded Primary Health Networks (PHNs) to undertake dedicated activities which support better health, wellbeing and access to primary care and aged care services for senior Australians.

The Enhanced out of hours support for residential aged care (RACF Afterhours) initiative aims to prevent unnecessary hospital presentations.

Using RACF Afterhours funds, Perth North Primary Health Network (PNPHN) will work with RACFs to address any awareness or utilisation issues of available local out-of-hours services among participating RACFs in the PHN region.

PNPHN will:

- Provide guidance to assist participating RACFs in the PHN region to develop and implement out-of-hours action plans which will support their residents to access the most appropriate medical services out-of-hours
- Educate participating RACF staff in out-of-hours health care options and processes for residents
- Encourage participating RACFs to implement procedures for keeping residents' digital medical records up to date, particularly following an episode where afterhours care was required
- Support engagement between RACFs and their residents' GP (and other relevant health professionals), as part of afterhours action plan development.

Description of Activity

Background
The GEN Aged Care Data Service list shows that there were 103 RACFs in PNPHN at 30 June 2023.

On 30 June 2019, PNPHN had a higher rate of residential care recipients per 1000 target population (41%) compared to the state (38%) (AIHW, 2020e) and the occupancy rate in RACFs was 89%. Many older people living in RACFs have complex health conditions, atypical symptoms, and multiple comorbidities. More than half (55%) of people using permanent residential care in the PHN had a diagnosis of dementia. (Ref: PNPHN Needs Assessment 2022-2024.)

Rationale
Research shows that substantial emergency department (ED) demand comes from patients living in RACFs. Residents can experience rapid health deterioration during the afterhours period, however immediate transfer to hospital is not always clinically necessary. Lack of awareness and utilisation of afterhours services provided by GPs and other health professionals can lead to unnecessary ED presentations and hospitalisations. Potentially Preventable Hospitalisation (PPH) data for 2017-18, identifies that 46% of all PPHs across Australia were for people aged 65 and over.

ED transfer may also result in an unnecessary burden to residents, resulting in invasive interventions and increased risk of delirium and hospital acquired infections.

Roles and responsibilities
WA Primary Health Alliance's (WAPHA's) Primary Care Innovation and Development Portfolio, which works across the three WA PHNs, is responsible for the delivery of the RACF Afterhours initiative. An executive sub-committee oversees all PNPHN aged care activity including the RACF Afterhours initiative to ensure it aligns with funding requirements and guidance, and WAPHA's Strategic Plan 2023-2026.

A small team, consisting of an activity lead and Digital Health Officers lead the RACF Afterhours initiative across the three WA PHNs. Place-based integration managers, and training and practice support staff assist the team and inform the activity development and implementation. A program logic guides activities.

Activities and key-activities
The RACF Afterhours initiative aligns with AC-VARACF 1000 - Support residential aged care facilities to increase availability and use of telehealth care for aged care residents' initiative. RACF Afterhours stakeholder engagement and data collection is undertaken simultaneously with activity AC-VARACF 1000 engagement. Activities will comply with the Aged Care Quality and Safety Commission's Aged Care Quality standards.

PNPHN will:

Communication and engagement:

- Engage with other PHNs to identify lessons learnt and opportunities to share resources / mirror activities.
- Engagement to gain an understanding of RACFs afterhours care plans and support, including disseminating surveys.
- Invite all RACFs to participate in the initiative to enhance afterhours action plans.
- Continue engagement with WA Health, and North and East Metropolitan Health. Services to ensure activities do not duplicate efforts underway to improve access to RACF afterhours care.
- Share relevant WA Health, and North and East Metropolitan Health Services virtual service information, and other related afterhours activity information with RACFs via WAPHA's Newsletters.
- Promote My Health Record (MyHR) and maintenance of resident digital medical records via WAPHA's Newsletters.
- Promote the uploading of advanced care planning documents into MyHR.
- Continue collaboration with key stakeholders throughout the activity to encourage the implementation of telehealth services in RACHs.

Resource development and education

- Seek advice from RACF representatives about what resources are required and their design.
- Develop and publish resources to assist RACFs to develop afterhours action plans and processes.
- Undertake an environmental scan to understand which services are available afterhours and share the information with RACFs.
- Encourage RACFs to work with residents so that afterhours wishes are included in resident's advanced care plans.

For participating RACFs

- Provide education to RACF staff in relation to out-of-hours health care, including options and processes.
- Facilitate the development and implementation of afterhours action plans to support residents access to the most appropriate health services' afterhours, including promoting advanced care planning.
- Encourage RACFs to implement procedures for keeping residents' digital medical records up to date, (use of MyHR) particularly following an episode where afterhours care was required.
- Support engagement between RACFs and residents' general practitioner and other identified health professionals, as part of afterhours action plan development.

- Provide ongoing support to participating RACFs in the development of afterhours action plans.

For non-participating RACFs

- Promote this initiative and encourage their engagement in the development of afterhours action plans.

Reporting

- Complete reports as per the executed agreement variation.

Perth North PHN Needs Assessment

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

Target Population Cohort

RACFs in the PHN region, with a particular focus on RACFs that wish to participate in the RACF Afterhours initiative, and general practitioners and other health professionals as relevant.

Coverage

Perth North PHN

Consultation

A range of stakeholders have been consulted throughout the planning and implementation of this activity including:

- Residential Aged Care Facilities
- WA Department of Health and Aged Care Directorate
- WA Department of Health, WA Virtual ED Project Team
- Residential Care Line Outreach Service
- North Metropolitan Health Service
- East Metropolitan Health Service
- Royal Australian College of General Practitioners
- General practitioner representatives.

This engagement will continue as required.

Collaboration

Participating RACFs and GPs.

Further collaboration with the WA Department of Health and East and North Metropolitan Health Services as the opportunity arises, such as sharing information about the WA Virtual ED Service with residential aged care providers via WAPHA's Aged Care Connect Newsletter.

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Workplan as amended and agreed by the Department as required as appropriate.	100%
The number of participating RACFs in the PHN region and the number that have been assessed as to whether they have an afterhours action plan.	100%
The PHN to provide a brief description of the training and support they have provided to RACF staff in relation to managing afterhours care and maintaining resident's digital medical information.	100%

Activity Milestone	Due Date
Activity Work Plan and Budget	30 April 2025
Twelve-month Performance Report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
After Hours Access in RACFs	$128,271.00	$308,336.23	$0.00

AC-EI 3000 - Commissioning early intervention initiatives to support healthy ageing and ongoing

Activity Title

Commissioning early intervention initiatives to support healthy ageing and ongoing

Activity Number

3000

Activity Status

Modified

PHN Program Key Priority Area

Aged Care

Aim of Activity

In response to the Royal Commission into Aged Care Quality and Safety, the Australian Government has funded Primary Health Networks (PHNs) to undertake dedicated activities which support better health, wellbeing and access to primary care and aged care services for senior Australians. The overarching goal of these activities is to delay entry in Residential Aged Care Facilities (RACFs) and reduce avoidable hospitalisations for older people.

The Commissioning early intervention initiatives to support health ageing and ongoing management of chronic conditions (Early Intervention) activity provides funds for Perth North PHN (PNPHN) to:

- Commission early intervention activities and models of care for chronic disease management that supports healthy ageing and reduces pressure on local health services
- Manage the performance of the commissioned services via performance monitoring and contract management, to ensure that the services are effective and efficient and meet the needs of the community
- Use training, tools, and resources to empower GPs and primary health care workers to undertake activities that contributes to improved health and care outcomes for older people at the participating general practices.

The overarching aim of the Early Intervention activity is to support healthy ageing and reduce pressure on local health services.

PNPHN Early Intervention activities focus on:

- Commissioning services to improve access to multi-disciplinary team-based care to older people with or at risk of chronic disease. The aim is to:
  - Prevent, identify, and reduce chronic disease and health issues
  - Avoid inappropriate hospital admissions.
  - Support healthy ageing in place.
  - Improve health outcomes for the elderly.
  - Building primary health care workforce (in targeted general practices) capability in the care of older people with or at risk of chronic disease.
  - Promoting self-management and health literacy in older people with or at risk of chronic disease.

Description of Activity

Background
Following Needs Assessment review, engagement with key stakeholders and consideration of policy direction and options:

- Pharmaceutical Services Australia (PSA) have been engaged to provide Older People's Non-Dispensing Pharmacists into targeted general practices. The contract was executed in late 2023. Participating practices have been identified through an expression of interest process
- Negotiation is occurring with other allied health providers to use the remaining funds.

Rationale
Today's Western Australians aged 65 and over are generally living longer and healthier lives than previous generations, and the population of older people is growing. Age is an important determinant of health and people aged 65 years and over are more likely to have complex and/or chronic conditions as well as comorbidities.

In 2021, there were over 170,000 people aged 65 years and over in PNPHN, representing about 16% of its population, similar to the state rate (Australian Bureau of Statistics, 2021a). This population is expected to increase by approximately 36% to 218,258 in 2030.

Roles and responsibilities
WA Primary Health Alliance's (WAPHA's) Primary Care Innovation and Development Portfolio, which works across the three WA PHNs, is responsible for the delivery of the Early Intervention initiative. An executive sub-committee oversees all PHN aged care activity including the Early Intervention initiative to ensure it aligns with funding requirements and guidance, and WAPHA's Strategic Plan 2023-2026.

A small team, consisting of activity leads and contract officer lead the Early

Intervention activities across the three WA PHNs. Place-based integration managers, and training and practice support staff assist the team. A program logic guides activities.

Target cohort

- Older people with or at risk of chronic disease in target locations, with a particular focus on improving access to services to improve health equity.

Key activities

The commissioned service providers will:

- Support collaborative approaches between multidisciplinary teams and primary care providers as an integral part of person-centered service delivery
- Recruit, provide support, and manage allied health staff to deliver services in participating general practices as contractually required or accept referrals from general practices
- Promote the service to the target general practices
- Collect and manage required data as agreed through contract negotiation
- Provide reports as specified in the contract to allow contract and performance management
- Ensure the delivery of culturally appropriate care.

The contracted allied health professional will:

- Build relationships between the general practice and other relevant services.
- Provide relevant interventions, including education to older people that access the service.
- Provide relevant education to the older people's family members or carers, as necessary, to meet the older person's health needs.
- Increase awareness of local primary health providers regarding needs of local older people and the local services available.
- Provide relevant information/education to the primary health care providers from the participating practices as needed
- Promote the uptake of digital health tools including My Health Record.
- Increase awareness of social initiatives and wrap around services that can support older adults to live at home.
- Implement the collection of Quality-of Life measures as agreed between the Contractor and WAPHA.

From 2024 PNPHN will focus on:

- Program management.
- Financial management including management of unspent funds.

- Commissioning additional services that meet the funding guidance where there are available funds.
- Completing and submitting Early Intervention initiative reports as per the agreement variation.

Contract management

- Management, monitoring, and evaluation of the performance of the commissioned services.
- Data collection and review.
- Promote the uptake of digital health tools including My Health Record.

Participating general practices

- Linking the Early Intervention initiative into participating general practices quality improvement activities, such as working with participating practices through WAPHA's Quality Improvement Coaches to identify at risk patients using Primary Sense.

Integration

- Promoting the PHN's other relevant commissioned services to the contractor as referral sources where appropriate.

Communication and engagement

- Sharing good news stories from the initiatives.
- Ongoing engagement with the participating practices through Primary Care Navigators and Quality Improvement Coaches.
- Providing information to the commissioned service provider via contract officers and WAPHA's Provider Connect Newsletter.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home	41
Promote early intervention and monitoring activities to support older adults to live at home and reduce early entry into residential care.	41

Target Population Cohort

Older people with chronic disease or at risk of chronic disease who attend participating general practices in targeted locations in the PNPHN region.

Coverage

Perth North PHN

Consultation

A range of stakeholders may be consulted throughout the planning, design and delivery phases of the Early Intervention activity including:

- WA Department of Health
- North Metropolitan Health Service
- General practitioners
- Commissioned Service Providers
- Pharmaceutical Services Australia
- Diabetes WA
- Aged Care Peak bodies and local government where appropriate
- Representatives from existing aged care service providers.
- General Practitioners
- Consumer representatives.

Collaboration

The PHN will continue to build on established relationships with the WA Department of Health, Health Service Providers, and local government authorities to:

- Ensure that the services funded through this activity complement existing support services available through the state and local government, and
- Facilitate the establishment of appropriate information sharing to support reporting on the effectiveness and impact of this activity.

General practice will be invited to participate in this activity.

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with he approved Activity Work Plan as amended and agreed by the Department as appropriate.	100%
The PHN will report on the number of consumers who have participated in the commissioned intervention activities.	100%
The PHN will report on the number of participants who sustained or	100%

improved their quality of life based on the International Consortium for Health Outcomes Measurement (ICHOM) older person standard assessment.	

Activity Milestone	Due Date
Activity Work Plan and Budget	30 April 2024
Twelve-month Performance Report	30 September 2024
Financial Acquittal Report	30 September 2024
Needs Assessment	15 November 2024

Activity Start Date	Activity End Date
5 January 2022	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Early Intervention	$1,345,082.09	$491,630.82	$0.00

AC-CF 4000 - Care finder program

Activity Title

Care finder program

Activity Number

4000

Activity Status

Modified

PHN Program Key Priority Area

Aged Care

Aim of Activity

In response to the Royal Commission into Aged Care Quality and Safety, the Australian Government has funded Primary Health Networks (PHNs) to undertake dedicated activities which support better health, wellbeing and access to primary care and aged care services for senior Australians. The overarching goal of these activities is to delay entry in Residential Aged Care Facilities (RACFs) and reduce avoidable hospitalisations for older people.

The care finder program aims to provide specialist and intensive assistance to help people within the care finder target population to understand and access aged care and connect with other relevant supports in the community.

To this end, WA Primary Health Alliance (WAPHA) will:

- Maintain the network of commissioned care finders in the Perth North PHN (PNPHN) region.
- Support and promote continuous improvement of the care finder program via a community of practice.
- Facilitate improved integration of care finders into the local health, aged care, and other community systems in the PHN region.

The care finder program aims to improve the health outcomes for people in the target population by facilitating equitable access and allocative efficiency to services. The intended outcomes are:

- Improved coordination of support when seeking to access aged care.
- Improved understanding of aged care services and how to access them.
- Improved openness to engage with the aged care system.
- Increased care finder workforce capability to meet client needs.

- Increased rates of access to aged care services and connections with other relevant supports.
- Increased rates of staying connected to the services needed post service commencement.
- Improved integration between the health, aged care, and other systems at the local level within the context of the care finder Program.

Description of Activity

Background
PNPHN commissioned care finder services to:

- Provide specialist and intensive assistance to help people within the care finder target population to understand and access aged care, and connect with other, relevant supports in the community.
- Specifically target people within the care finder target population.
- Deliver the functions set out in the 'Care finder policy guidance for PHNs'.
- Respond to local needs in relation to care finder support.
- Engage appropriately qualified, skilled, and trained workforce to deliver services to the care finder target population.

PNPHN engaged existing Assistance and Care and Housing (ACH) Program providers (Australian Red Cross Society, People Who Care and St Bartholomew's House) to support provider transition to the care finder program. ACH providers commenced care finder service delivery from 1 January 2023, with a focus on the specialist area of older people at risk of or experiencing homelessness.

In addition to ACH providers, the PHN procured new care finder services for the PHN region (Advocare Incorporated, City of Stirling, Chung Wah Association, Dementia and Alzheimer's Australia, Umbrella Multicultural Community Care Services Inc.) through an open tender process utilising findings from the care finder Needs Assessment.

Rationale
The aged care system is complex, and some people find it more difficult than others to navigate and access services. The care finder target population include people who require intensive support for; access to My Aged Care (either through the website, contact centre or face-to-face in Services Australia service centres), access to aged care services, and/or access other relevant supports in the community.

In 2021, there were over 170,000 people aged 65 years and over living in the PHN region, representing about 16% of its population, similar to the state rate. While it is difficult to accurately measure the size of the PHN's target care finder population, data

analysis indicates that the largest groups include people from non-English speaking backgrounds and people who require assistance with cognitive and emotional tasks. However, other groups also require support such as Care leavers, people with previous experiences with trauma, and older people who identify as Aboriginal or LGBTIQ+.

Roles and responsibilities
WAPHA's Commissioned Services Portfolio, which works across the three WA Primary Health Networks (PHNs), is responsible for the delivery of the care finder initiative. An executive sub-committee oversees all PNPHN aged care activity including care finders to ensure it aligns with funding requirements, guidance, and WAPHA's Strategic Plan 2023-2026.

The contract management, place-based integration manager and program improvement teams work together to lead integrated care finder activities across the three WA PHNs. A program logic guides activities.

Key activities

Program management

- Share Department provided information to care finders as required.
- Collect and maintain data on the number and type of care finders within the PHN region, provider contact details, the geographic reach by LGA of each provider and the number of providers who were ACH providers.
- Notify the Department of any changes to care finder locations in a timely manner to ensure the care finder website is current.
- Monitor the care finder program at PHN level and make changes when necessary and informed by provider service agreements to ensure and effective and efficient PHN care finder network.
- Engage with and contribute to the evaluation of the care finder program.
- Collaborate and share lessons learnt with other PHNs.

Contract management

- Monitor and manage the performance of service providers informed by submitted data.
- Ensure providers collect and submit monthly reports to the online reporting portal.
- Ensure new providers complete the mandatory MAC Learning Training.

Program improvement

- Facilitate and maintain the WA care finder community of practice for providers, using deidentified data to inform quality improvement activities and connection with key stakeholders.

Integration

- Support local (sub-regional) and regional integration of the care finder services into the broader aged, health and community sectors.
- Engage with WA Elder Care Support (ECS) program managers and providers to facilitate a cooperative relationship and referral of clients (where appropriate) between care finder and ECS providers.
- Promote care finders and their target population with key stakeholders, such as WA Department of Communities and Health Aged and Community Care Policy Teams, and aged care assessment teams.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Promote early intervention and monitoring activities to support older adults to live at home and reduce early entry into residential care.	41
Support people living with dementia and their carers to navigate the aged care system and access appropriate services.	41
Support Aboriginal people to navigate the primary care system and access appropriate services.	34

Target Population Cohort

The target population for care finder support are people eligible for aged care services and who have one or more reasons for requiring intensive support. Reasons for requiring intensive support may include isolation or no support person; communication barriers; difficulty processing information to make decisions; or resistance to engage with aged care institutions, or government.

Target population sub-groups to be prioritised for care finder support includes:

- People living with dementia
- Care leavers
- People with previous experiences of trauma
- Aboriginal and Torres Strait Islander people
- Lesbian, gay, bisexual, transgender, intersex, or queer people
- Culturally and linguistically diverse people

Coverage

Perth North PHN

Consultation

The PHN will engage the following organisations and groups to support the establishment of care finders:

- Department of Health and Aged Care Regional Stewardship Team
- North Metropolitan Health Service
- East Metropolitan Health Service
- District Leadership Groups
- Aged Care Interagency Groups
- Local government authorities
- Council of the Ageing WA
- Aged and Community Care Providers Australia, formerly Leading Aged Services Australia and Aged Care Services Australia.
- National Aboriginal Community Controlled Health Organisation (NACCHO)
- Aboriginal Health Council of WA (AHCWA)
- Aboriginal Community Controlled Health Services (ACCHSs) and Aboriginal Community Controlled Organisations (ACCOs) as relevant.

Collaboration

The PHN will continue to build on established relationships with key stakeholders.

The PHN will collaborate with NACCHO, AHCWA, and relevant ACCHSs and ACCOs in the establishment of the Elder Care Support Program throughout the PHN region.

In addition, the PHN will collaborate with the wide range of stakeholders supporting the care of older Australians in Western Australia, when relevant, including:

- WA Department of Health
- Health service providers
- Local government authorities
- Sector peak bodies and service providers.

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department as appropriate.	100%
Number and type of care finder services delivered in the PHN region.	Non identified

Number of care finder clients in the PHN region.	Non identified
Proportion of Closed care finder Client Cases in the PHN region within care finder complexity bands 2 (5 to up to 10 hours of support) to 4 (15+ hours of support).	≥ 70%
Proportion of care finder Clients in the PHN region within the care finder Target Population	≥ 90%
Proportion of surveyed care finder Clients in the PHN region who reported outcomes based on questions asked in care finder client surveys administered as part of the Activity.	≥ 85% (to be assessed against each question in the care finder survey related to improved outcomes).
Number and type of training courses completed by care finders in the PHN region.	Non identified
The PHN provides a brief description in its 12-month Performance Reports of at least two activities undertaken each 12-month period to assist in integrating the care finder network into the local aged care system.	100%
The PHN provides a brief description in its Twelve-Month Performance Reports of at least two examples each 12-month period of how knowledge of local experiences, lessons learned, innovations or key evaluation findings has been applied to support continuous improvement of the care finder Program	100%
The PHN provides a brief description in its Twelve-Month Performance Reports of at least one activity undertaken as part of the care finder Program each 12-month period to enhance integration between the health, aged care, and other systems within the context of the care finder Program.	100%

Activity Milestone	**Due Date**
Activity Work Plan and Budget	30 April 2024, 30 April 2025
Annual Activity Needs Assessment	15 November 2024, 15 November 2025
12-month performance report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025
Final performance Report	30 September 2025

Monthly care finder reports	10th of the month for the duration of activity
Case studies and reflection	10 October 2024

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

Service Delivery Start Date	**Service Delivery End Date**
1 January 2023	30 June 2025

Activity Planned Expenditure

Funding Stream	**FY 23 24**	**FY 24 25**	**FY 25 26**
Care Finder Program	$2,257,631.71	$2,426,249.01	$0.00
To support transition from the ACH Program	$151,635.16	$153,909.69	$0.00

END