WA Primary Health Alliance PHN Core Country WA 2024/25 - 2027/28 Activity Summary View

Approved by the Australian Government Department of Health, Disability and Ageing, October 2025

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GPACI-TM 3010 - GP in Aged Care: Thin Markets

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

GPACI-TM

Activity Number

3010

Activity Title

GPACI-TM 3010 - GP in Aged Care: Thin Markets

Existing, Modified or New Activity

New Activity

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

People living in residential aged care homes (RACHs) in the Country WA Primary Health Network (CWAPHN) region can experience a lack of access to primary care services. These thin market areas can be due to limited access due to temporary/ongoing workforce shortages, insufficient service availability and/or limited resident choice. These challenges are often exacerbated in rural and remote areas due to the tyranny of distance.

Australian Institute of Health and Wellbeing data shows that in 2020/21 GP attendances per Country WA RACH resident was 16.1. This decreased to 15.3 in 2021/22; lower than the national rate of 16.8. This lack of access impacts both the residents' health outcomes and experience and local hospitals, with older people's delayed discharge to RACHs due to a lack of GP access.

The General Practice in Aged care Incentive (GPACI) – Thin Markets grant provides $1,395,294 for CWAPHN to support and commission an innovative and local solution to address a lack of primary care services for permanent residents living in residential aged care homes (RACH) in a target location within the PHN.

The aim of this activity is to:
• Identify existing gaps in the delivery of primary care services to RACH residents within the CWAPHN region.
• Work in collaboration with local RACH providers, general practices, and/or Aboriginal Community Controlled Health Services (ACCHS) to design and implement locally appropriate solutions to increase resident access to primary care services in an area of need within the CWAPHN region.

The intended outcomes of the grant opportunity for residents in the identified target area are:
• Improved access to primary health care from a regular health care provider.

• Increased number of regular health assessments, care planning services and regular visits from primary care providers.
• Improved quality and continuity of primary care services.

Description of Activity

Background
On 30 June 2024, 87 facilities (38 multipurpose services [MPSs] and 3 National Aboriginal and Torres Strait Islander Flexible Aged Care Program [NATSIFACP] sites) provided residential care in CWAPHN. These RACHs made approximately 3600 residential aged care places available to older people living in Country WA.

In the absence of Medicare Benefits Schedule data by RACH/community, CWAPHN has considered a range of elements to inform the Thin Market priority location, including:
• Number and location of RACHs and places, and general practices and general practitioners (GPs) by SA3/SA2.
• Number of small practices (less than five GPs) by SA3.
• Proportion of people experiencing socio economic disadvantage.
• Workforce statistics: areas of workforce priority.
• General population demographics, including the percentage of people that identify as Aboriginal and/or Torres Strait Islander and people who were born outside of Australia.
• The uptake of aged 75 years and older health assessments.
• Rates of older people potentially preventable hospitalisations (SA3).
• Stakeholder intelligence which identifies locations where there are issues in delivering primary care services to RACH residents or people wishing to enter RAC, and how persistent the issues have been/are.
• Existing related assets and planned activities, including evidence of integration and existing service models and relationships, that may be leveraged within an SA3.
• The willingness and capacity of stakeholders to participate in this activity.

Three SA3 geographical locations; Bunbury, Busselton and Wheatbelt-North were identified as priority locations within Country WA PHN. Further stakeholder consultation has determined Busselton/Dunsborough as the priority location for the Thin Market activity.

Roles and responsibilities
WA Primary Health Alliances (WAPHAs) Primary Care Portfolio, which works across the three WA Primary Health Networks, is responsible for the delivery of this activity. An executive sub-committee oversees all CWAPHN aged care activity including GPACI activities to ensure they align with funding requirements and guidance, and WAPHAs Strategic Plan 2023-2026.

An activity lead, regional integration manager and procurement/contract officer will lead the activity. Place-based practice support members will assist the team. A program logic will guide activities.

The local solution
In collaboration with key stakeholders, CWAPHN will design and implement a range of strategies to address gaps in the delivery of primary care services to aged care residents in the area of need (evidenced by qualitative and quantitative data).

Subject to further engagement in the target location, the strategies may include expanding the role of Nurse Practitioner/Practice Nurses to provide and coordinate primary care service delivery.

Key activities
WAPHA's activities and the new service model will be underpinned by the PHN Cooperative principles of successful design in thin markets and value-based care principles:
• Consultation and co-design with primary and residential aged care providers and residents to ensure that the model of care is contextualised and appropriate to meet local needs.
• Acute service connection (local referral pathway development/refinement, enhanced wrap around support from hospital/specialist services).
• Building local capacity and leveraging existing capability to deliver integrated resident focused care.
• Creation of attractive, supportive, and collaborative team-based employment settings.

• Creation of a workforce model that offers rewarding positions and employment arrangements and supports career options.
• Identifying and re-organising/optimising all available funding models to support care provision and sustainability of the service.
• Digitally enabled service delivery: promotion and building capability with the use of Telehealth, My Health Record and the electronic National Residential Medication Chart.
• Measuring outcomes and costs. The development of meaningful activity-based and outcome related measures, incorporating both clinician and patient reported outcomes and experience, and utilising data to implement quality improvement.

The planned phased approach
Additional engagement to confirm need, including consultation with RACH and primary care providers/Aboriginal Community Controlled Health Services (ACCHSs) to confirm capacity and appetite to collaborate in the initiative.

Co-design of the service model with participating providers, including establishment of governance structures and measures, such as agreements.

Implementation
• Service procurement.
• Contract management.
• Facilitation of relationships.
• Assistance to increase GP and practice MyMedicare registration and GPACI linkage.

Monitoring and evaluation.
• Establishing/maintaining indicator data collection processes.
• Data collection, analysis and reporting.
• Ongoing engagement with the Department of Health and Aged Care, and participation in national Communities of Practice.

To support GPs, general practice and the commissioned service, CWAPHN will leverage existing well established WAPHA business support functions including real-time data analytics to inform best practice and quality improvement opportunities to deliver the Thin Market activity requirements.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to local aged care services, including residential and at-home (Goldfields-Esperance).	8
Enable access to local aged care services, including residential and at-home (Pilbara).	97
Enable access to age-appropriate digital health services (Pilbara).	97
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Mid West).	73
Enable access to age-appropriate digital health services (Mid West).	73
Enable access to local aged care services, including residential and at-home (Mid West).	73

Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Goldfields-Esperance).	7
Enable access to age-appropriate digital health services (Goldfields-Esperance).	7
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (South West).	120
Enable access to age-appropriate digital health services (South West).	120
Enable access to local aged care services, including residential and at-home (Kimberley).	53
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Wheatbelt).	142
Enable access to age-appropriate digital health services (Wheatbelt).	142
Enable access to local aged care services, including residential and at-home (Wheatbelt).	142
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Great Southern).	31
Enable access to age-appropriate digital health services (Great Southern).	31
Enable access to age-appropriate digital health services (Kimberley).	51

Activity Demographics

Target Population Cohort

General practitioners, general practices/ACCHS and RACHs in the Busselton/Dunsborough area.

Indigenous Specific

No

Whole Region

No

SA3 Name	SA3 Code
Augusta - Margaret River - Busselton	50101

Activity Consultation and Collaboration

Consultation

Consultation has or is planned to occur with:
• WA Department of Health Intergovernmental Relations and Aged and Community Teams.
• Department of Health and Aged Care WA, local network.
• WA Country Health Service (WACHS), relevant hospitals and WACHS Virtual Command Centre.
• General practitioners and general practices in the target location (Broadwater Medical Centre, Brecken Health, Busselton Medical Practice, Duchess Medical, Sunshine Medical Centre and Family Practice, Power Medical, Surgery 82, Cape Naturaliste Medical Centre, Dunn Bay Surgery, Dunsborough Medical Centre), and others outside of the target population that may be able to assist in the model development or service delivery.
• Residential aged care providers in the target locations (Cape Care Broadwater, Cape Care Dunsborough, Aegis Ellenvale, Baptist William Caret Court).
• Aboriginal Health Council of WA.
• ACCHSs in the target location.
• National MyMedicare Project Team.
• PHN Aged Care Leads.
• Ageing Australia (formerly ACCPA) (WA State Manager).
• Aged Health /McClean Health representatives.

Collaboration

Engagement and collaboration will occur with primary care and residential aged care providers in a targeted area of need to:
• Ensure that the model of care is contextualised and appropriate to meet local needs.
• Inform the refinement and evaluation of the model through established performance measures.

WAPHAs place based regional integration managers and practice support team members will inform the model development and assist with identifying and managing relationships with key local stakeholders.

Activity Milestone Details/Duration

Activity Start Date

31/05/2024

Activity End Date

29/06/2027

Service Delivery Start Date

30/07/2025

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/06/26, 30/06/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25,30/09/26, 30/09/27

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: Yes
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
General Practice in Aged Care–Thin Markets	$0.00	$499,521.00	$446,600.00	$449,173.00	$0.00	$1,395,294.00
Total	**$0.00**	**$499,521.00**	**$446,600.00**	**$449,173.00**	**$0.00**	**$1,395,294.00**

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

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

CF-COVID-VVP

Activity Number

8000

Activity Title

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

Existing, Modified or New Activity

Modified

Activity Priorities and Description

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 older members of the multicultural community, residential aged care home residents, people with a disability, 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.

Analysis of WA Primary Health Alliance (WAPHA) needs assessment and other data indicates that the focus locations to target vulnerable populations are SA3s Bunbury, Greater Geraldton, Albany, Murray, and Collie. First Nations priority areas (LGA's with the highest volume of First Nations people, and the lowest rate of COVID vaccination rates in the last 6 months) were identified as Broome, West Kimberley, Greater Geraldton and Port Hedland. These will be priority locations to work with Aboriginal communities and services to increase COVID-19 vaccination rates. Residential aged care facilities (RACFs) in Country WA PHN with COVID-19 vaccination rates of 0-30% full coverage will also be a priority population.

The PHN will:
1. Collaborate with COVID-19 vaccination providers including general practice, pharmacy, PHN contracted providers, state health services and nurse practitioners to enable access of the COVID-19 vaccination to vulnerable people in identified priority locations.

2. Facilitate partnerships and work with local government, community organisations and Aboriginal Community Controlled Health Services on tailored solutions to suit local context.
3. Communicate existing relevant COVID-19 assessment and vaccination funding mechanisms for vaccination services to GPs and health professionals.
4. Explore innovative strategies to enhance vaccination rates among target cohorts, leveraging the expertise of pharmacists and registered vaccination providers. This will include initiatives such as outreach services and educational events tailored to address prevalent barriers hindering COVID-19 vaccine uptake.
5. Build the capacity of key providers (e.g., RACFs, general practice, pharmacies, nurses, and Aboriginal Community Controlled Health Services) to provide sustainable vaccination services to vulnerable community members.

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

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2022-2024

Priorities

Priority	Page reference
Improve access to culturally appropriate services for Aboriginal people in the South West.	71
Investigate successful alternatives to the provision of primary care in Emergency Departments in country regions. (Midwest)	56
Improve access to coordinated culturally appropriate primary care for Aboriginal people. (Goldfields/Kimberley)	15
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Goldfields, Midwest, Wheatbelt, South West,)	15
Ensure primary care services are available for people with chronic conditions that provide a holistic approach to management including improving self-management. (Kimberley)	43

Activity Demographics

Target Population Cohort

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

Indigenous Specific

Yes

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.

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

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

Collaboration

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

Activity Milestone Details/Duration

Activity Start Date

08/09/2021

Activity End Date

30/12/2024

Other Relevant Milestones

Activity Work Plans	Due 30/04/25
Annual Activity Needs Assessment	Due 15/11/24
12-month performance report	Due 30/09/25
Financial Acquittal Report	Due 30/09/25

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
COVID-19 Vaccination of Vulnerable Populations	$778,340.35	$1,347,013.31	$0.00	$0.00	$0.00	$2,125,353.66
Total	**$778,340.35**	**$1,347,013.31**	**$0.00**	**$0.00**	**$0.00**	**$2,125,353.66**

MyM 2500 - My Medicare

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

MyM

Activity Number

2500

Activity Title

MyM 2500 - My Medicare

Existing, Modified or New Activity

New Activity

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

This activity enables WAPHA to identify and assist unaccredited practices in Country WA PHN to work towards accreditation, thereby increasing the number of general practices accredited, and the number of practices eligible for MyMedicare and other Commonwealth funded programs.
The new Royal Australian College of General Practitioners (RACGP) definition of general practice for accreditation purposes has broadened the opportunity for some non-traditional general practices to become accredited to the RACGP standards. WAPHA will work with those practices to inform the rationale and benefits of accreditation, and the practical application of the 5th edition standards to their specific type of practice.

The intended outcomes of this activity are:
· An increase in general practice accreditation.
· Improvements in safety and quality.
· Improved access of general practice to Commonwealth funded programs such as MyMedicare.

Description of Activity

Background:
General practice accreditation is independent recognition that practices meet the requirements of the governing national industry Standards. Accreditation means a practice is meeting minimum safety and quality standards.[1] In Australia the National General Practice Accreditation (NGPA) scheme supports the consistent assessment of general practices against the Royal Australian College of General Practitioners (RACGP) Standards for General Practice 5th Edition (the Standards).

The definition of a general practice for the purpose of accreditation was broadened by RACGP in April 2024, meaning that previously ineligible services may now fit the eligibility criteria to become accredited.

Accreditation against the RACGP Standards for general practice is a pre-requisite for general practices to access the Commonwealth Practice Incentives Program (PIP), Workforce Incentives Program (WIP) and MyMedicare financial incentives, which support health professionals and practices to deliver quality, multidisciplinary care, enhance capacity and improve access.

Core funding supports the operations of WAPHA to develop resources and supports to assist the unaccredited practices in Country WA PHN to achieve accreditation where desired, which is a prerequisite for participation in MyMedicare.
Practice support includes (but is not limited to):
• Assistance for general practices going through accreditation or accreditation processes.
• Provision and access to resources and information to assist with preparation for accreditation.
• Assistance maintaining conformance to the accreditation standards.
• Reducing or resolving barriers to accreditation.

Roles and Responsibilities
WAPHA's Primary Care Portfolio, which works across the three WA PHNs, is responsible for delivering the My Medicare accreditation activity. An executive sub-committee oversees all CWAPHN population health activity including MyMedicare to ensure it aligns with funding requirements and guidance, and WAPHA's Strategic Plan 2023-2026.

Stakeholder Engagement
• Undertake an analysis of the accreditation status and eligibility of all general practices in CWA PHN.
• Targeted engagement with non-accredited general practices to understand barriers and enablers to accreditation.
• Managing expectations of general practices regarding WAPHA's role in accreditation support.

Building Capacity
• Promote the broadened definition of general practice and the benefits of accreditation.
• Promote available resources and education opportunities to increase knowledge and understanding of the accreditation process and requirements.
• Information will be provided about eligibility and requirement for MyMedicare registration, along with other PIP/WIP incentives.
• Provide Quality Improvement support to practices who are interested in seeking accreditation.

Monitoring
• Maintain accurate general practice accreditation data within CRM.
• Activity data collection and reporting.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Pilbara).	96
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Goldfields-Esperance).	7

Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Enable access to coordinated culturally appropriate primary care for Aboriginal people (South West).	119
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Mid West).	72
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Support primary health care providers to promote healthy lifestyle changes and improve screening for chronic disease risk factors (Great Southern).	30
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Great Southern).	31
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Kimberley).	51

Activity Demographics

Target Population Cohort

Unaccredited general practices located within Country WA PHN

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The PHN will engage the following organisations or groups to support implementation of this activity:
• General practices, both accredited and non-accredited.
• Engagement with Royal Australian College of General Practitioners (RACGP).

Collaboration

The PHN will continue to build on established relationships with key stakeholders, including:
• Royal Australian College of General Practitioners.
• The Department of Health and Aged Care.

Activity Milestone Details/Duration

Activity Start Date

31/05/2024

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2024

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/06/26, 30/06/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
12-month performance report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27
Final Report	

Progress reports including:
· List of general practices in your region working towards accreditation under the National General Practice Accreditation Scheme.
· List of withdrawn general practices and reason for withdrawal under the National General Practice Accreditation Scheme
· List of unaccredited general practices under the National General Practice Accreditation Scheme
PQF indicators:
· P3 Rate of general practice accreditation
· P4 Support provided to general practices and other health care providers

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Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
MyMedicare	$0.00	$54,974.50	$10,994.90	$10,994.90	$0.00	$76,964.30
Total	**$0.00**	**$54,974.50**	**$10,994.90**	**$10,994.90**	**$0.00**	**$76,964.30**

GPACI-GPM 3020 - GP in Aged Care: GP Matching

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

GPACI-GPM

Activity Number

3020

Activity Title

GPACI-GPM 3020 - GP in Aged Care: GP Matching

Existing, Modified or New Activity

New Activity

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The General Practice in Aged Care Incentive (GPACI) - GP Matching initiative provides funds for the Country WA Primary Health Network (CWAPHN) to work in collaboration with Residential Aged Care Homes (RACHs), general practitioners (GPs), practices, and Aboriginal Community Controlled Health Services (ACCHSs) to develop processes, relationships and networks to increase access of older people living in RACHs to primary care services.

To this end, CWAPHN's objectives are to:
• Collaborate and engage with aged care home providers, GPs and general practices and ACCHS in their region, including establishing arrangements between stakeholders where appropriate.
• Develop processes and strategies to connect and establish relationships between older people living in aged care homes and aged care homes with primary care, especially in cases where no relationship currently exists. This includes providing support to facilitate visits to older people living in aged care homes to encourage continuity of care.
• Develop or use existing tools to support stakeholders to sign up and appropriately use the MyMedicare platform.
• Identify and share examples of best practice arrangements between aged care home providers, GPs and general practices and ACCHS in your region, this may include through establishment of networks to improve capacity.

The activities undertaken by CWAPHN aim to:
• Increase the knowledge of GPs, and general practice and ACCHS staff working in Country WA of the incentive and its benefits to older people living in aged care homes and residential aged care providers.

• Improve reciprocal relationships between GPs, general practices and ACCHS in Country WA and residential aged care providers to facilitate the delivery of quality and continuous primary care services.
• Improve the capacity of GPs, general practices and ACCHS in Country WA to deliver quality and continuous care through collaborative learning networks and/formalised arrangements, and the embedding of Best Practice Guidelines and Tools.

Description of Activity

Background
GEN Aged Care 2024 Aged Care Service list identifies 87 RACHs in CWAPHN at 30 June 2024, of these 38 are Multi-Purpose Services (MPS) provided by the WA Country Health Service (WACHS), and three are National Aboriginal and Torres Strait Islander Aged Care Program sites. These sites provide approximately 3,600 residential places across Country WA's vast 2.55million square kilometres. Consistent with the findings from the Royal Commission into Aged Care Quality and Safety and Strengthening Medicare Taskforce, country RACH residents can experience inconsistent/a lack of access to primary care services.

Roles and responsibilities
WA Primary Health Alliance's (WAPHA's) Primary Care Portfolio, which works across the three WA PHNs, is responsible for delivering this activity. A Strategic Alignment Group oversees all CWAPHN aged/primary care activity including GP Matching to ensure it aligns with funding requirements and guidance, and WAPHA's Strategic Plan 2023-2026.

An activity lead guides the design, coordination, development, implementation and evaluation of the activity. The GPACI is promoted by WAPHA, at a State and CWAPHN level through established relationships and mechanisms with WA Department of Health, WACHS, Department of Health and Aged Care (DoHAC) WA Local Network, Aboriginal Health Council of WA, and key aged and primary care sector stakeholders.

Targeted place-based activities are/will be undertaken by the Activity Lead, and by/with the support of WAPHA's primary care support, Practice Assist, Quality Improvement Coaches, Regional Integration Managers and Digital Health team members. These activities build on the established and trusted relationships with RACHs, GPs and general practice and ACCHSs employees. A program logic guides activities.

Key activities
1. Stakeholder engagement and collaboration.
• Engagement with individuals and small group forums, will inform activity design and identify RACHs and primary care providers (including ACCHSs) willing to participate in activities.
• Existing relationships established through the country aged care networks/collaboratives, practice support and the PHN's RACH Telehealth, Afterhours planning and COVID Vaccination activities will be maintained.
• Existing/new relationship development and engagement will be prioritised in areas of high need, with collaborating providers.
• Activities will align with WAPHA's Cultural Competency Frameworks (Aboriginal, Multicultural, and LGBTIQA+, Equity and Diversity).
• Recording engagement activities in WAPHA's Stakeholder Relationship Management system.

2. Needs analysis will identify the extent of issues, barriers, opportunities, priority populations (Aboriginal and Multicultural) and locations, and local context (such as workforce availability) and inform activity design, implementation, and monitoring.
• Barriers, and best practice examples will be shared with the Department of Health and Aged Care and PHNs via the National PHN MyMedicare Project Team and related forums.
• Managing expectations will be required due to the anticipated volume of need across CWAPHN. Assistance will be available via Practice Assist and a webpage which will direct stakeholders to the DoHAC developed best practice resources.

3. Building capability and understanding
• Participation in GPACI related national discussions/forums.

• Information/education will be provided to primary care providers (including ACCHSs) and RACHs about the GPACI process, requirements and benefits, including resident MyMedicare registration information via practice support staff, Practice Assist and webinars.
• Assistance and advice will be provided to support GPs and general practice/ACCHS initial MyMedicare registration and GPACI payment requirements.
• DoHAC provided/authorised information and resources (best practice guidelines and tools) will be shared via WAPHA's existing communication channels (including newsletters and webpages).
• Resources will be developed/refined as/if required.
• Webpages which connect providers to the DoHAC information will be maintained.

4. Program design and implementation
• Relationships between primary care and RACH providers include encouraging the development of business processes to facilitate GP and resident connection, and adoption of agreements which outline roles and accountabilities will be facilitated.
• The GP Matching activities will connect to and build on CWAPHN activities being undertaken to deliver My Medicare support for general practice accreditation.
• WAPHA will leverage existing partnerships and practice support functions that are well established and access real-time data analytics to inform best practice and opportunities for quality improvement and efficiencies.
• Access to culturally appropriate information and resources to support RACH residents having a choice in their provider will be promoted.

5. Monitoring and evaluation
• Establishing and maintaining indicator data collection processes.
• Data collection, analysis, and reporting.
• Ongoing engagement with the DoHAC.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to local aged care services, including residential and at-home (Goldfields-Esperance).	8
Enable access to local aged care services, including residential and at-home (Pilbara).	97
Support health care and aged care providers in delivering patient-centred culturally appropriate care for older Aboriginal people (Pilbara).	97
Enable access to culturally appropriate local aged care services for Aboriginal people aged 50+ years (Pilbara).	97
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Mid West).	73
Enable access to local aged care services, including residential and at-home (Mid West).	73

Support health care and aged care providers in delivering patient-centred culturally appropriate care for older Aboriginal people (Mid West).	73
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Pilbara).	96
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Goldfields-Esperance).	7
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Goldfields-Esperance).	7
Enable access to coordinated culturally appropriate primary care for Aboriginal people (South West).	119
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Mid West).	72
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (South West).	120
Enable access to culturally appropriate local aged care services for Aboriginal people aged 50+ years (Mid West).	74
Enable access to local aged care services, including residential and at-home (Kimberley).	53
Support health care and aged care providers in delivering patient-centred culturally appropriate care for older Aboriginal people (Kimberley).	53
Enable access to culturally appropriate local aged care services for Aboriginal people aged 50+ years (Kimberley).	53
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Wheatbelt).	142
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Wheatbelt).	142
Enable access to local aged care services, including residential and at-home (Wheatbelt).	142
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Great Southern).	31
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Great Southern).	31
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Kimberley).	51

Activity Demographics

Target Population Cohort

Primary care workforce, particularly GPs, and practice/RACH staff in priority locations within the CWAPHN in their role / possible role as providers primary care service providers to RACH residents.

Residential aged care provider executives and managers, and RACH staff that coordinate care in facilities.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

CWAPHN has consulted/plans to consult with and will continue to engage with a range of stakeholders in the planning and delivery of the GP Matching activity, including:

State / country wide:
• WA GP Panel – Special Interest Group: Care of the older person members.
• The Department of Health and Aged Care's WA Local Network team
• WA Aged Care Collaboration Group (The Department of Health and Aged Care's WA Local Network facilitated group)
• WA Aged Care Collaborative (CEOs from Juniper, Brightwater, Southern Cross Care, Baptistcare, Hall & Prior, Amana Living and Bethanie).
• Ageing Australia WA State Manager
• WA Department of Health Aged Care leads.
• Aboriginal Health Council of WA.
• WACHS Aged and Primary Care leads

Local place-based engagement will occur in prioritised areas of high need with willing providers/stakeholders.
• Residential Aged Care provider representatives (operational managers and leads), for example RACHs that have received equipment via the RACH Telehealth initiative, and Cape Care Busselton and Dunsborough.
• GPs and general practice/ACCHS representatives, for example general practices in Geraldton and GPs and practice located in Northern and Southern Wheatbelt and Busselton.
• South West Aged Care Collaborative
• Great Southern Aged Care Collaborative/Network
• Wheatbelt Aged Care Collaborative/Network
• Midwest Aged Care Collaborative/Network

A stakeholder engagement and communications plan guides CWAPHN activities.

Collaboration

CWAPHN will collaborate with stakeholders and providers to ensure activity requirements are delivered.

These will include prioritising willing/receptive providers in areas where there is high need:
• GPs and general practice/ACCHS employees that seek assistance with MyMedicare registration and GPACI linkage, and an interest in providing primary care services to RACH residents. The WAPHA team will collaborate to:
o Provide the requested assistance to increase MyMedicare registration and GPACI linkage.
o Connect GPs wishing to provide services in RACHs to RACHs.
• GPs, general practice/ACCHS employees and RACH leads to facilitate greater connection and relationship development related to the GPACI, such as via the Great Southern Aged Care Network.

At a national level WAPHA collaborates with members of the National MyMedicare Project team and other PHN representatives to share examples of innovative models of care, lessons learnt, and barriers and opportunities.

Activity Milestone Details/Duration

Activity Start Date

31/05/2024

Activity End Date

29/06/2027

Service Delivery Start Date

01/06/2024

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/2025, 15/11/2026
12-month performance report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27
Final Report	Due 30/09/27

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): Yes
Other Approach (please provide details): No

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
General Practice in Aged Care–GP Matching	$0.00	$113,724.00	$113,724.00	$113,724.00	$0.00	$341,172.00
Total	**$0.00**	**$113,724.00**	**$113,724.00**	**$113,724.00**	**$0.00**	**$341,172.00**

CMDT 5320 - Commissioning Multidisciplinary Teams

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

CMDT

Activity Number

5320

Activity Title

CMDT 5320 - Commissioning Multidisciplinary Teams

Existing, Modified or New Activity

New Activity

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

As part of the 2023-24 federal budget Strengthening Medicare Reform measures, the Department of Health and Aged Care announced $77.35 million for PHN's to commission multidisciplinary teams (MDT) into general practice.
The purpose of this grant opportunity is to strengthen the role PHNs play in commissioning multidisciplinary health care teams to improve the management of chronic conditions and reduce avoidable hospitalisations.

The objectives of the grant opportunity are to:

· Design an approach for multidisciplinary team services in the PHN region based on:
o Identification of, and consultation with, small or solo general practices or Aboriginal Community Controlled Health Services that are unable to engage a multidisciplinary team through other funding streams, and
o Identification and prioritisation of areas of need in underserved or financially disadvantaged communities (such as treating chronic conditions and injuries, coordinating care for priority patients, mobilising social supports for at risk patients).
• Successfully commission multidisciplinary teams that address the prioritised need in the region, with a focus on supporting smaller general practices that do not have the size or scale to engage the range of health professionals required to provide effective multidisciplinary care.
• Extend PHNs' existing role in general practice to support private allied health, nursing and/or midwifery practices.

• Establish reporting processes supported by data collection and data management practices, including both activity and outcome measures.
• Monitor implementation of the activity, utilising relevant outcome measures, and develop adjustments to the approach if required.

The intended outcomes of the grant opportunity are to:
• Increase access to allied health, Aboriginal Health Worker/Practitioner, nurse practitioner, nursing, and/or midwifery services to provide person-centred care for Australians that improves health outcomes and reduce avoidable hospitalisations, particularly in relation to chronic disease.
• Improve attraction and retention of allied health, Aboriginal Health Worker/Practitioner, nursing, nurse practitioner and midwifery professionals in the primary care sector by increasing access to practice support from PHNs.

Description of Activity

Background
The Strengthening Medicare Taskforce report (Dec 2022) and Australia's Primary Health care 10-Year Plan (Mar 2022) both highlight the importance of a multidisciplinary approach to primary care, to meet the increasingly complex care needs of Australians. This is further explored in the 2024 Health of the Nation report which indicates that a well-resourced, multidisciplinary primary healthcare team has the capacity to coordinate high quality care and ensure patients care achieve the best possible health outcomes.

Rationale
Australians seek care from a range of different health professionals across primary care and other care settings, which can mean that accessing appropriate care can become complex and disconnected. Our current funding mechanisms reward episodic care and fast throughput which creates disproportionate barriers for more vulnerable populations: Aboriginal Australians, people with chronic and complex conditions, people with mental health issues, people from culturally and linguistically diverse backgrounds and people on low incomes. Connection and collaboration through coordinated multidisciplinary care teams can improve engagement and access and deliver better outcomes to help people better manage their own health.

WA Primary Health Alliance (WAPHA) will develop and successfully commission a multidisciplinary team-based approach to primary care in a Country WA PHN area of need.

Roles and Responsibilities
WAPHA's Primary Care Portfolio, which works across the three WA Primary Health Networks (PHN's) is the Lead portfolio responsible for the delivery of multidisciplinary teams into general practice. A dedicated Activity Lead will provide ongoing coordination, engagement and monitoring. The Commissioned Services Portfolio lead the procurement element of this activity and will provide contract management and program improvement support.

Key Activities - Commissioning:
The successful implementation of an effective and localised multidisciplinary team-based service will be influenced by following phased activities:
Planning and engagement
• Analysis of population, workforce and practice data to determine priority locations for service delivery.
• Consultation with WAPHA GP advisory panel and Commissioned Service Provider (CSP) panel regarding need and access to MDT, and exploration of opportunities and challenges.
• Recruitment of a dedicated Activity Lead to coordinate ongoing activities including developing relationships with peak bodies, ongoing support to CSP and general practices and other practice support activities.
• Targeted consultation with general practices and health service providers within identified priority locations in CWA PHN, to determine gaps and opportunities in local primary care workforce and implementation of MDT, and appetite for participation in activity.
Procurement and co-design
• Procure a service provider to engage a number of health professionals – type to be determined through general practice consultation – to provide a shared, visiting MDT to a selection of general practices within CWA PHN.
• Support selected general practices and the commissioned service provider to develop a model of MDT care

that will address the needs of the local community, including how to measure the success of the initiative by identifying key performance measures.
Implementation
• Continued engagement with commissioned service and general practices, both formally and informally, to ensure opportunities for iterative changes and adaptation of service to local needs.
• Support local integration of MDT service into the broader local health environment.

Proposed Activities – Practice Support:
To support general practice, commissioned services and primary health professionals, WAPHA will leverage existing partnerships and practice support functions that are well established and access real-time data analytics to inform best practice and opportunities for quality improvement and efficiencies. The Activity Lead will coordinate these activities with support of established practice-facing teams.
Activities may include but are not limited to:
• Engage and build relationships with Peak organisations for allied health, nursing, nurse practitioners, midwives and Aboriginal health professionals.
• Maintain close relationships with CSP's and participating general practices.
• Establish a Learning Group or similar forum to enable primary care providers to identify challenges, participate in interdisciplinary approaches/learning, review practice and subsequent outcomes, share approaches/learnings and align to and inform the ongoing development of the MDT approach.
• Identify opportunities for further education and/or quality improvement which may include analysis of a particular patient cohort, clinical workflows or opportunities for local integration with other health services.
• Analyse and provide feedback to CSP regarding Patient Reported Experience Measure (PREM) and Patient Reported Outcome Measure (PROM), as well as clinician experience (practice and CSP) data, to allow for the collaborative development of solutions and improvements to the MDT service.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Mid West).	73
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Pilbara).	96
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Goldfields-Esperance).	7
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Goldfields-Esperance).	7
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Enable access to coordinated culturally appropriate primary care for Aboriginal people (South West).	119

Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Mid West).	72
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (South West).	120
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Wheatbelt).	142
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Great Southern).	31
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Great Southern).	31
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Kimberley).	51

Activity Demographics

Target Population Cohort

Patients of selected general practices within the Country WA PHN region. Priority locations to include Geraldton, Morawa and Mullewa.

Indigenous Specific

No

Coverage

Whole Region

No

Activity Consultation and Collaboration

Consultation

The PHN will continue to build on established relationships with key stakeholders, including:
- GP Advisory Panel
- Service Provider Panel
- Internal locally based WAPHA team members
- Targeted general practices within the priority locations
- Allied health peak bodies
- Rural Health West
- Western Australian Country Health Service
- WAPHA internal and place-based teams
- Health service providers

Collaboration

The PHN will continue to build on established relationships with key stakeholders:
- WAPHA internal and place-based teams
- Selected general practices – GP's, practice managers, practice nurses
- Commissioned service provider
- Western Australian Country Health Service

Activity Milestone Details/Duration

Activity Start Date

31/05/2024

Activity End Date

29/06/2028

Service Delivery Start Date

01/07/2025

Service Delivery End Date

30/06/2028

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/06/26, 30/06/27, 30/04/28
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26, 15/11/27
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27, 30/09/28
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27, 30/09/28

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: Yes
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Commissioning Multidisciplinary Teams - Administration	$0.00	$228,953.34	$231,717.33	$234,530.33	$0.00	$695,201.00
Commissioning Multidisciplinary Teams - Commissioning	$0.00	$766,500.00	$777,500.00	$788,500.00	$0.00	$2,332,500.00
Total	**$0.00**	**$995,453.34**	**$1,009,217.33**	**$1,023,030.33**	**$0.00**	**$3,027,701.00**

WIP-PS 7000 - Workforce Incentive Program

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

WIP-PS

Activity Number

7000

Activity Title

WIP-PS 7000 - Workforce Incentive Program

Existing, Modified or New Activity

New Activity

Activity Priorities and Description

Program Key Priority Area

Workforce

Aim of Activity

In the 2023-24 federal budget, the Department of Health and Aged Care announced a range of activities which were aimed at implementing the recommendations from the Strengthening Medicare Taskforce Report. The Workforce Incentive Program-Practice Stream (WIP-PS) is a current Department of Health and Aged Care incentive to assist general practices to employ non-medical health professionals (nurses, midwives, allied health, Aboriginal Health professionals) to encourage a multidisciplinary team-based approach to primary care.

This activity aims to:
• Understand current utilisation of WIP-PS in Country WA PHN.
• Identify and provide additional support to practices addressing gaps in WIP-PS Knowledge.
• Identify different models of multidisciplinary care supported by the WIP-PS to address community need, and the key factors that enable or inhibit these models and to share learnings.
• Identify the range of activities nurses and allied health professionals undertake in primary care supported by the WIP-PS.
· Increase general practice participation in the WIP-PS.
· Improve patient outcomes by improved access to multidisciplinary care in communities.
· Identify best practice models of care supported by WIP-PS and
· Have general practices providing sustainable, quality multidisciplinary team care.

Description of Activity

Background
The Workforce Incentive Program-Practice Stream (WIP-PS) provides financial incentives to eligible general practices, Aboriginal Community Controlled Health Services (ACCHS) and Aboriginal Medical Services (AMS) to engage a range of health professionals including nurses, midwives, allied health professionals and Aboriginal and Torres Strait Islander health workers and health practitioners.
In 2023-24, a review was undertaken by the Department of Health and Aged Care as part of the Strengthening Medicare Reform measures, to analyse the effectiveness and impact of the current Practice incentive and Workforce Incentive payments. This activity will provide local insights into the utilisation of the WIP-PS, gaps in knowledge about the incentive and different models of care practices are implementing supported by WIP-PS.

Rationale
Australians seek care from a range of different health professionals across primary care and other care settings, which can mean that accessing appropriate care can become complex and disconnected. Our current funding mechanisms reward episodic care and fast throughput which creates disproportionate barriers for more vulnerable populations: Aboriginal Australians, people with chronic and complex conditions, people with mental health issues, people from culturally and linguistically diverse backgrounds and people on low incomes. Connection and collaboration through coordinated multidisciplinary care teams can improve engagement and access and deliver better outcomes to help people better manage their own health.

Country WA PHN will undertake activities to better understand what types of health professionals are employed within general practice, what types of tasks they undertake and what types of models of care are being implemented with the support of WIP-PS.
WAPHA will deliver a range of activities in Country WA PHN, including:
• Stakeholder engagement, practice collaboration and communication.
• Data collection, reporting and analysis.
• Implementation of strategies for enhancing multidisciplinary models of care in practices.

Roles and Responsibilities
WAPHA's Primary Care Portfolio, which works across all three WA Primary Health Networks (PHN's), is the lead portfolio responsible for undertaking the WIP-PS activity. The Primary Care Navigation and Quality Improvement teams work together to engage with and support general practices in their understanding and application of the WIP-PS, with support from the Primary Care Learning team.
Key Activities
Country WA PHN will:
Initial Data collection and analysis
• Review Department WIP-PS data, internal CRM data and Primary Sense general practice data to identify practices both approved and not approved for the WIP-PS, as well as practices who engage non-medical workforce.
• Identify priority locations within Country WA PHN where general practices may benefit from additional support to understand and apply multidisciplinary care and the utilisation of WIP-PS.
• Identify general practices where multidisciplinary care is taking place.

General practice engagement
There are two streams of delivery within this funding:
1. Engage with general practices who are already utilising the WIP-PS, to assist them to identify practice gaps and opportunities to improve multidisciplinary care.
2. Engage with general practices who do not currently utilise the WIP-PS but who are eligible, to provide resources and information about the benefits of multidisciplinary care and the WIP-PS for supporting comprehensive person-centred care in the community.

General practice information
• Provide information and learning opportunities to assist practices utilising the WIP-PS -topics may include but are not limited to opportunities and challenges of multidisciplinary care and enhance multidisciplinary workflows to support patient care and business efficiencies.
• Provide information and learning opportunities to general practices that are eligible for but not yet utilising the WIP-PS, promoting the purpose of the incentive, eligibility, value proposition to practice and patients, and application process.

General practice support
• Provide support to implement quality improvement activities that enhance or expand multidisciplinary team care.
• Provide support to implement quality improvement activities that build practice team capacity to participate in multidisciplinary team care.

Case Studies
Through already established relationships, WAPHA will identify general practices who are already utilising the WIP-PS to implement multidisciplinary care and engage with those practices to document the challenges and benefits of their model of care and how the WIP-PS assists them to maintain this type of service.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Mid West).	73
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Pilbara).	96
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Goldfields-Esperance).	7
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Goldfields-Esperance).	7
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Enable access to coordinated culturally appropriate primary care for Aboriginal people (South West).	119
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Mid West).	72
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (South West).	120
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Wheatbelt).	142

Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Great Southern).	31
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Great Southern).	31
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Kimberley).	51

Activity Demographics

Target Population Cohort

Target population for the WIP-PS activity are general practices, ACCHS and AMS's, with activities specifically targeted at:
1. General practices who are not currently utilising or approved for the WIP-PS.
2. General practices utilising the WIP-PS.

CWA PHN will prioritise those general practices delivering services to the most vulnerable patient cohorts including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, older persons, people living in rural and remote areas and people experiencing socioeconomic disadvantage.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The PHN will engage the following organisations or groups to support implementation of this activity:
Internal
· Regional Integration Managers
· Primary Care teams
· Data and analytics team
External
· General practices

· Aboriginal Community Controlled Health Services
· Aboriginal Medical Services
· Services Australia
· Department of Health and Aged Care

Collaboration

The PHN will continue to build on established relationships with key stakeholders:
· Aboriginal Health Council of WA
· General practices
· ACCHS and AMSs
· Rural Health West

Activity Milestone Details/Duration

Activity Start Date

31/05/2024

Activity End Date

29/06/2025

Service Delivery Start Date

01/09/2024

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Activity Work Plans	Due 30/04/25
Twelve Month Performance Report	Due 30/09/25
Financial Acquittal Report	Due 30/09/25
Final Report	Due 30/09/25

Departmental survey and online forums - Survey Due 15/06/25
PHNs must participate in a Departmental survey and online forums in 2024-25 to provide updates on PHN support to general practices and general practice participation in the Workforce Incentives Program – Practice Stream.
Final Report
• Identify if and how outcomes were achieved, including justification of the outcome measures utilised for practices.
• Current utilisation of WIP-PS in PHN region;
• How practice support was implemented and any barriers to implementation.
• PHN method of engagement with practice. Could include insights, support/education that has been offered, employment types, numbers and percentage of practices, types of engagement such as seminars, surveys, workshops, phone, visits;
• How multidisciplinary team services were improved through support, including changes made to implement better models of care.
• Identify barriers to practices utilising WIP-PS;
• Suggestions on potential areas for improvements to WIP-PS policy to support more effective multidisciplinary primary care in communities;
• Provide examples of models and case studies of effective multidisciplinary care to address patient needs and outline the types of support provided to practices to implement and integrate these models.
• Identify the total eligible expenditure incurred.

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Workforce Incentive Program-Practice Stream	$0.00	$101,064.50	$0.00	$0.00	$0.00	$101,064.50
Total	**$0.00**	**$101,064.50**	**$0.00**	**$0.00**	**$0.00**	**$101,064.50**

CF 1000 - Managing Chronic Conditions

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

CF

Activity Number

1000

Activity Title

CF 1000 - Managing Chronic Conditions

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The WA Primary Health Alliance (WAPHA) Managing Chronic Conditions Program aims to improve patient access to primary health care, provide coordinated care, reduce potentially preventable hospitalisations, and strengthen patient self-management for people with chronic conditions.
The key objectives are to:
· Improve patient experience,
· Improve health outcomes,
· Improve health literacy and self-management,
· Increase interagency /cross sector connection, integration, and collaboration.
· Strengthen chronic conditions management in primary care,
· Minimise chronic conditions preventable hospitalisations and Emergency Department presentations
· Improve health equity and primary health care outcomes for priority populations and
· Locate place-based services in priority community locations.

The chronic conditions targeted by this program include diabetes; respiratory conditions such as chronic obstructive pulmonary disease (COPD) and asthma; obesity, chronic pain, and cardiovascular conditions, such as chronic heart failure (CHF).

Description of Activity

Background
Almost half of Australians (47 per cent, or 11.6 million people) were estimated to have one or more of 10 selected chronic conditions in 2020–2021.

In Western Australia, chronic conditions and injury cause the highest burden of disease than any other diseases. The health care expenditure is much higher per capita in Country WA, than in the metropolitan regions, and is predominantly related to hospitalisations.

The Health and Wellbeing of Adults in Western Australia 2022 indicated that for adults over the age of 16 years:
· Asthma (lifetime) 18.3 per cent, in the Kimberley, Pilbara and South West regions.
· Diabetes, 9.8 per cent, in the Goldfields-Esperance, Mid-west, Southwest and Wheatbelt regions.
· Respiratory Diseases other than Asthma 5 per cent, in the Kimberley region
· Heart Disease 8.2 per cent, in the Goldfields-Esperance, Kimberly, Midwest and Pilbara regions.
· Stroke 2.2 per cent.
· Obesity 27.9 per cent, in the Goldfields-Esperance, Great Southern, Mid-west, Southwest and Wheatbelt regions.

Rationale:
Chronic disease is a major contributor to health burden in Australia and some people are disadvantaged due to inequitable access to resources needed to address risk to health and/or have an increased susceptibility to adverse health outcomes. This includes regional, rural, and remote residents, LGBTIQA+ and multicultural community members, older adults and Aboriginal people who experience higher risk of chronic health conditions. Data show that people living in rural and remote areas have higher rates of hospitalisations, deaths, injury and have poorer access to, and use of, primary health care services, than people living in major cities. As a result, residents living in rural and remote Western Australia are generally unable to access multidisciplinary health care providers for the management of chronic conditions which hinders the effective management of their condition.

Background
Almost half of Australians (47 per cent, or 11.6 million people) were estimated to have one or more of 10 selected chronic conditions in 2020–2021.
In Western Australia, chronic conditions and injury cause the highest burden of disease than any other diseases. The health care expenditure is much higher per capita in Country WA, than in the metropolitan regions, and is predominantly related to hospitalisations.
The Health and Wellbeing of Adults in Western Australia 2022 indicated that for adults over the age of 16 years:
Chronic Condition Percentage of the population diagnosed in WA Priority regions (WAPHA needs assessment)
Asthma (lifetime) 18.3%0.3% Great Southern, Kimberley, Pilbara, South West Wheatbelt, Midwest
Diabetes 8.85%9.8% All country regions Goldfields-Esperance, Mid-west, Southwest, Wheatbelt
Respiratory Diseases other than Asthma 4.9%5% Kimberley, Midwest, South West and Wheatbelt
Heart Disease 7.6%8.2% Great Southern, Midwest, Goldfields, South West
Goldfields-Esperance, Kimberly, Midwest, Pilbara
Stroke 2.3%2.2% Great Southern, Midwest, Wheatbelt
Obesity Country 43.3% 37.9% Goldfields-Esperance, Great Southern, Mid-West, Southwest, Wheatbelt The prevalence of obesity was significantly higher in the country population compared to the metropolitan population (34.2%). Great Southern, Midwest and Wheatbelt regions were significantly higher than the State.

Rationale:
Chronic disease is a major contributor to health burden in Australia and some people are disadvantaged due to inequitable access to resources needed to address risk to health and/or have an increased susceptibility to adverse health outcomes. This includes regional, rural, and remote residents, LGBTIQA+ and multicultural community members, older adults and Aboriginal people who experience higher risk of chronic health conditions. Data show that people living in rural and remote areas have higher rates of hospitalisations, deaths, injury and have poorer access to, and use of, primary health care services, than people living in major cities. As a result, residents living in rural and remote Western Australia are generally unable to access multidisciplinary health care providers for the management of chronic conditions which hinders the effective management of their condition.

Key Activities in the Country WA PHN:
The Managing Chronic Conditions Program provides care coordination and nursing and allied health services, tailored to the needs of each of the seven country health regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.

Services consist of:
Integrated Chronic Disease Care (ICDC).
• Multidisciplinary teams providing clinical and self-management support for vulnerable and disadvantaged persons with chronic diseases, with priority given to people with cardiovascular, diabetes and respiratory conditions.
• Care coordinators working to ensure clients are followed-up, receive the best wrap around care and are linked successfully with general practice and their GP or Aboriginal Community Controlled Health Service, other appropriate health professionals and social support services.
• Culturally appropriate support and information to enable patients to work towards self-management of their condition.
• The use of evidence based self-management apps and other digital health technology in a patient's care plan to monitor their health and wellbeing. The model also includes group based self-management interventions.
PHN-wide services:
• Chronic Respiratory Disease and Diabetes Telehealth Services: these services work in partnership with local GPs and healthcare professionals to ensure continuity of care for patients. They provide one on one support/ consultations and education to support patient self-management in country WA via telephone and video-conferencing.
• Health Navigator telehealth service: This service is part of the Managing Chronic Conditions model and aims to improve the health and quality of life of vulnerable, disadvantaged or otherwise eligible people who have, or are at risk of developing, chronic conditions by supporting them to address barriers to health care access and engagement and develop a personal plan that enables progression towards self-management of their chronic condition. The service is provided in the Great Southern, Wheatbelt and South -West regions.
• Country to City – Improving Patient Transitions Project focuses on the coordination of health and other care elements and to improve the health journey of ITC clients across WA and support providers to apply continuous quality improvement to the Country to City. This includes but is not limited to the service model, standardised processes and improving communication, information sharing and discharge planning.

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

The PHN continues to develop and maintain close working relationships with contracted service providers and plans to formally review services to determine:
• How well targeted and efficient services are.
• How effective services and systems are in relation to patient reported experiences and patient reported health outcomes service/system integration.
• Service sustainability including provider experience/governance, formal accreditation requirements against industry standards (with appropriate financial support) and service cost effectiveness.
• Integration with the Strengthening Medicare reform agenda.

The PHN uses a diverse range of data collection methods to evaluate the performance of services and inform any necessary actions, including:
• Patient level episode and service contact data.
• Using the WA Primary Health Alliance Performance Management Framework (PMF), the PHN measures and tracks providers' performance against specified PMF indicators relating to health equity, patient-reported experiences and outcomes and cost effectiveness. This includes Provider reports formally reviewed at 6 month and 12-month intervals.
• Referral agency feedback.
• Commissioned Services Reporting Portal for nominated ICDC providers.

A comprehensive review of all PHN chronic conditions activities commenced mid 2024 due for completion in late 2025. This review will inform service planning for future chronic conditions services. Targeted performance indicators for chronic condition services have been implemented from 1 July 2023 along with improved frequency and depth of activity and outcome reporting.

The CF 4000 Healthy Weight Activity (all country regions), CF5000 Strengthening General Practice in WA, CF 2000 Developing System Capacity and Development, HSI 1000 Health Service Improvement and HSI 1020 Clinician Assist WA support the CF 1000 Chronic Conditions and ITC 3000 Country to City Patient Transitions Project activities.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary care to promote healthy weight and healthy lifestyle changes (South West).	118
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Pilbara).	96
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Goldfields-Esperance).	7
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Enable access to coordinated culturally appropriate primary care for Aboriginal people (South West).	119
Support primary care to promote healthy weight and healthy lifestyle changes (Goldfields-Esperance).	5
Enable access to best-practice management for people with coronary heart disease or chronic heart failure (Goldfields-Esperance)	5
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Mid West).	72
Support primary care to promote healthy weight and healthy lifestyle changes (Wheatbelt).	141
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Support primary care to promote healthy weight and healthy lifestyle changes, including smoking cessation (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Great Southern).	31

Enable access to coordinated culturally appropriate primary care for Aboriginal people (Kimberley).	51

Activity Demographics

Target Population Cohort

People with diabetes; respiratory conditions including chronic obstructive pulmonary disease (COPD) and asthma; obesity and cardiovascular conditions, such as chronic heart failure, and who require support to manage their condition/s. This includes:
• Individuals with a complex chronic condition or multiple morbidities.
• Individuals experiencing socio-economic disadvantage.
• Individuals with limited or no access to required care through other services.
• Aboriginal people.
• Individuals who identify as lesbian, gay, bisexual, transgender, intersex, queer, asexual and other sexually or gender diverse.
• Culturally and linguistically diverse populations.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Ongoing consultation with service providers occurs through contract management, the chronic conditions care community of practice, service providers connect newsletters and meetings.
A review of the chronic conditions care program included engagement with the following key stakeholders where recent, relevant consultation has not occurred to inform any changes to the activity:
• WAPHA team members.
• General practitioners and general practice staff.
• Other relevant primary care providers including allied health professionals and commissioned service providers.
• Australian Government Department of Health (including other PHNs).
• State departments of health and health service providers.
• Aboriginal Community Controlled Health Services.
• Other key service providers e.g., Rural Health West, Royal Flying Doctor Service, Silver Chain, Asthma Foundation, Diabetes WA.
• Cohorts of possible service users.

Collaboration

Stakeholders will be provided with an opportunity to:
• Provide feedback on barriers and opportunities and priorities to be addressed in relation to chronic care conditions primary care services in Country WA PHN.
• Identify opportunities to enhance person and family centred care, integration and collaboration between the

primary care, acute health systems and other sectors in each Country WA PHN.
• Recommend activities for future commissioning and workforce development.

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2019

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27
Final Report	Due 30/09/27

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: Yes
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Core Flexible	$10,508,893.24	$11,360,661.82	$11,465,027.81	$10,947,985.25	$0.00	$44,282,568.12
Total	**$10,508,893.24**	**$11,360,661.82**	**$11,465,027.81**	**$10,947,985.25**	**$0.00**	**$44,282,568.12**

CF 2000 - Developing System Capacity/ Integration

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

CF

Activity Number

2000

Activity Title

CF 2000 - Developing System Capacity/Integration

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The key aim of Developing System Capacity and Integration is to support the primary health care sector by:
• Providing general practitioners and primary health care clinicians with an online health information portal (Clinician Assist WA) to assist with management and appropriate referral of patients when specialist input is required.
• Facilitating integrated holistic services to reduce the impact of chronic disease by providing enablers for service and patient level integration.
• Providing general practice with access to platforms that support patient centred care through the extraction and analysis of general practice data.
• Providing general practice, clinical, and business teams with access to critical business information in a timely, safe, and secure manner.

Description of Activity

Background
The WAPHA Strategic Plan 2023-2026 commits the organisation to ensuring the best value for money through commissioning integrated primary health services that build capacity, capability and sustainability and measurably improve health outcomes. To meet this commitment, WAPHA supports the provision of tools to support secure digitally enabled health care, continuous improvement and development of integrated primary health care services.

Key principles for an integrated health system include:
• Comprehensive services across the care continuum, from health promotion to primary and tertiary level care, as well as cooperation between health and social care organisations.

• A patient centred approach, accessibility, minimal duplication of key services.
• Standardisation with a focus on multidisciplinary care.
• Performance management.
• Efficient information systems.

The complexity of delivering health care in the Country WA PHN is significant and exacerbated by distance, climate, lack of resources, human and infrastructure, IT and communications, and social determinants of health.

Rationale

Australia is facing an ageing and growing population with an increasing prevalence of complex chronic conditions and higher expectations for quality care. Health outcomes for people living in WA's rural and remote locations are significantly poorer than in metropolitan areas . Health budgets are limited and require healthcare to be delivered equitably and be cost effective . Key elements for an integrated health system in country regions include use of telehealth, online care protocols and the use of secure technology as an enabler to support the collection of resources, information and rapid diagnosis by isolated clinicians . An integrated health system that builds capacity is critical to ensuring sustainability and a focus on flexibility and adaptation to the local context. There is no one size fits all model or process that guarantees success however literature reviews indicate the above key principles build an integrated health system over time.

WAPHA will consistently review and enhance enabling technologies that deliver critical business information and guidance to General Practitioners, as well as Clinical and Business teams, in a timely, safe, and secure manner.

Key activities

To support the overarching aim of this AWP, WAPHA delivers the following activities:

1. Delivery of Clinician Assist WA (replacing HealthPathways as an interim solution pending Department of Health and Aged Care decision)

Clinician Assist WA is a web-based tool designed to guide general practitioners (GPs) and other health professionals in making appropriate, patient-focused decisions, particularly regarding the management of a variety of patient presentations and the local referral process. It offers primary care clinicians locally agreed information to make the right decisions, together with patients, at the point of care.

It is designed and written for use during primary care consultation. It provides detailed clinical pathways which are locally agreed upon and evidence-based guidance for assessing and managing patient presentations. Clinician Assist WA content is tailored to specific regions, providing localised information about referral options, services available in the area, and local management guidance. The development of Clinician Assist WA content often involves collaboration between GPs, specialists, subject matter experts and other health professionals. The content is regularly reviewed and updated to reflect the latest research and changes in clinical practice.

The future of Clinician Assist WA is contingent upon the Department of Health, Disability and Aged Care's decision regarding the funding of a National Clinical Referral platform for use by all Primary Health Networks (PHNs) under AWP CF-PHI-5060. The determination of this funding will dictate the subsequent actions required by WAPHA:

1) Approval for a national platform is backed by funding outlined in AWP CF-2000, with additional funds necessary to support the development of a WA-specific version.

2) A national platform is unsupported, requiring investment to make the interim platform fit for purpose.

Country WA PHN also purchased the license to access the GPBook Specialist Directory via a widget embedded within the Clinician Assist WA website. This provides up to date, accurate information to general practitioners about private specialists within the PHN region, with the ability to search by practitioner name, specialty, gender, language, telehealth availability, and billing.

2. Commissioned Services Reporting Portal (CSRP).

WAPHA aims to develop a comprehensive data set and create performance dashboards for all commissioned services. This will enable access to accurate, timely and high-quality performance data which will enable:

• Data-driven decisions that will provide better value for money commissioning and improved provider performance management.
• Deliver better value services in line with WAPHA's Performance Management Framework.
• Improved data security and governance.
• Monitoring and evaluating standards and capabilities to ensure that commissioned services are effective and efficient and meet the community's needs.

3. Primary Care Reporting Portal.
WAPHA is investing in the development of the Primary Care Reporting Portal. It is an encrypted platform with validated access control enabling a safe and secure method of delivery and access for all general practices sharing data. With access to real-time reporting of practice information, key reports, insights, and other data, WAPHA has developed and provided performance dashboards to general practices within this portal, supporting the monitoring and improvement of their performance as well as ensuring the delivery of value-based services. WAPHA will continually enhance this platform by implementing self-service administration and the development of additional reports that support General Practice.

4. Primary Sense Installation and ongoing management and continuous improvement.
Primary Sense is a population health management, clinical decision support and data extraction tool that helps GPs deliver the right care to patients at the right time. WAPHA has purchased the Primary Sense license, managed implementation across the PHN and developed continuous improvement strategies. The license allows WAPHA to extract general practice data for practice analysis and aggregates general practice data for service planning, reporting and population health needs.
As WAPHA's data extraction tool of choice, the cost of Primary Sense will be fully subsidised for all general practices in WA and WAPHA continues a roll out of Primary Sense software to all general practices in the region.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Kimberley).	50
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Mid West).	73
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Mid West).	73
Enable access to culturally appropriate mental health care and early intervention suicide prevention services, including for young people (South West).	118
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Enable access to early screening and treatment for harmful alcohol use and support primary health care providers in managing alcohol-related issues (Pilbara).	96
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Pilbara).	96
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Goldfields-Esperance).	7
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95

Enable access to culturally appropriate mental health and early intervention suicide prevention services and support primary health care providers in identifying people at risk (Pilbara).	95
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (South West).	119
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (South West).	120
Enable access to culturally appropriate mental health care and early intervention suicide prevention services, including for young people (Wheatbelt).	141
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Wheatbelt).	142
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Enable access to culturally appropriate mental health and early intervention suicide prevention services and support primary health care providers in identifying people at risk (Kimberley).	49
Enable access to early screening and treatment for harmful alcohol use and support primary health care providers in managing alcohol-related issues (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Enable access to early screening and treatment for harmful alcohol use and support primary health care providers in managing alcohol-related issues (Great Southern).	30
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Great Southern).	31
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Great Southern).	31
Enable access to culturally appropriate mental health and early intervention suicide prevention services and support primary health care providers in identifying people at risk (Great Southern).	29

Activity Demographics

Target Population Cohort

The Country WA PHN population, including WAPHA's priority community groups such as Aboriginal, LGBTIQA+ and multicultural community members, those experiencing homelessness, those experiencing family domestic sexual violence, those with a disability and older people.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The Country WA PHN will continue liaison with the following stakeholders:
- General practices
- General practitioners
- Community and commissioned service providers
- WA Country Health Service (WACHS)
- Residential Aged Care Facilities
- Aboriginal Community Controlled Health Services

Collaboration

Ongoing engagement with key stakeholders to ensure that the services/activities are meeting the needs of the community and service providers.

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2019

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27
Final Report	Due 30/09/27

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: Yes
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Core Flexible	$586,549.23	$762,748.53	$382,040.17	$331,520.39	$0.00	$2,062,858.32
Total	**$586,549.23**	**$762,748.53**	**$382,040.17**	**$331,520.39**	**$0.00**	**$2,062,858.32**

CF 2010 - PHN Clinical Referral Pathways

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

CF

Activity Number

2010

Activity Title

CF 2010 - PHN Clinical Referral Pathways

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Population Health

Other Program Key Priority Area Description

Aim of Activity

This activity:
• Develops, enhances and maintains clinical and referral pathways (including content specific to aged care and dementia) on the Clinician Assist WA website (formerly HealthPathways) relevant to the Primary Health Network (PHN).
• Enhances linkages between primary health care services, other providers, and relevant services.
• Improves the patient journey and health outcomes.
• Increases clinician capabilities and the quality of care provided.
This activity aims to:
• Develop, review, enhance and maintain content on the Clinician Assist WA website.
• Maintain the relationship with the website developers to support the operation and administration of the Clinician Assist WA website.
• Increase the awareness of, engagement with, and utilisation of Clinician Assist WA by primary care clinicians in the region.
• Provide and increase awareness of current best practice guidance for a wide range of primary care patient presentations.
• Enhance clinician awareness of and access to local referral options and services for patients.
• Improve collaboration with and integration across health care and other systems.

Description of Activity

Clinician Assist WA content is developed, reviewed and enhanced as appropriate to the health needs of the Country WA PHN. Content is for use by clinicians during consultation with patients, supporting patient assessment and management and referral to local services and supports.
Clinical and Referral webpage development, enhancement, review and maintenance will include the following activities:
• Consultation with subject matter experts, peak bodies and clinicians.
• Mapping, documenting and maintaining currency of local support and referral services information.
• Engaging with the website developers to ensure the website remains available, functional, secure and maintained, and to provide technical support as required.
• Literature review, drafting and editorial activities.
• Monitoring, reviewing and improving existing website content to ensure currency, accuracy and consistency with best practice.
• Identification of information gaps in the Clinician Assist WA library and subsequent consideration for new developments or incorporation of information into an existing page/s as required.
• Identification and escalation of gaps in care/service availability, for consideration to support health system improvements.
• Identification and inclusion of reputable resources suitable for health professionals and patients.
• Development and delivery of targeted educational activities, supporting the awareness and integration of Clinician Assist WA into clinical practice.
• Promoting newly published and/or reviewed pages, in addition to audience specific pathways, to a wide range of health professionals.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support health and aged care providers in supporting older people live independently for as long as possible (Pilbara).	97
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Mid West).	73
Support primary care to promote healthy weight and healthy lifestyle changes (South West).	118
Support General Practices in identifying people at risk of suicide and referring to appropriate services, including telehealth mental health providers (South West).	118
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Goldfields-Esperance).	7
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Support primary care to promote healthy weight and healthy lifestyle changes (Goldfields-Esperance).	5
Improve the rates of cancer screening to reduce avoidable deaths from cancer (Goldfields-Esperance).	5

Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (South West).	120
Support primary care to promote healthy weight and healthy lifestyle changes (Wheatbelt).	141
Support General Practices in identifying people at risk of suicide and referring to appropriate services, including telehealth mental health providers (Wheatbelt).	141
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Support primary care to promote healthy weight and healthy lifestyle changes, including smoking cessation (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support General Practices in identifying people at risk of suicide and referring to appropriate services, including telehealth mental health providers (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Great Southern).	31
Support health and aged care providers in supporting older people live independently for as long as possible (Kimberley).	51

Activity Demographics

Target Population Cohort

The activities will focus primarily on general practitioners, in addition to other health professionals, including primary care clinicians and allied health professionals practicing in the Country WA PHN.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation will continue to 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 (HSP).
• WA Department of Health.
• Clinician Assist WA Users (GPs practicing in WA; other registered clinicians and some non-clinicians (approved case by case)) .
• Other PHN regions across Australia.

The PHN promotes Clinician Assist WA to specific audiences at conferences (e.g., RACGP annual conference, 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 Clinician Assist WA website and support users to maximise integration into their clinical practice.
• Launch new and newly reviewed Clinician Assist WA content, in conjunction with other PHN initiatives and in collaboration with SMEs, HSPs and peak bodies (e.g. Dementia Care in General Practice, Eating Disorders event, Transgender Health and Gender Diversity webinar series).

Collaboration

Developing relationships and collaborating with key 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 (SMEs) Including hospital clinicians, non-general practitioner medical specialists, allied health practitioners, nurses etc.).
· Consumer representatives, GPs, peak bodies (e.g. Diabetes WA, Australasian Society of Clinical Immunology and Allergy (ASCIA)) to:
o Inform clinical and referral website content.
o Provide representation and specialist expertise in working groups related to Clinician Assist WA development and/or review.

Clinician Assist WA website developers The PHN is supported by and collaborates with the website developers who built the Clinician Assist WA website and now provide ongoing technical and website maintenance support.
· Other stakeholders as they are identified.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2022

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27
Final Report	Due 30/09/27

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
HealthPathways	$230,887.80	$285,939.24	$318,704.82	$324,125.21	$0.00	$1,159,657.07
Total	**$230,887.80**	**$285,939.24**	**$318,704.82**	**$324,125.21**	**$0.00**	**$1,159,657.07**

CF 2011 - Aged Care Clinical Referral Pathways

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

CF

Activity Number

2011

Activity Title

CF 2011 - Aged Care Clinical Referral Pathways

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Aged Care

Aim of Activity

In response to the Royal Commission into Aged Care Quality and Safety, Primary Health Networks (PHNs) have been funded to undertake clinical and referral pathways activities specific to aged care, including:
• Developing, enhancing and maintaining clinical and referral pathways on the Clinician Assist WA website (formally HealthPathways) specific to aged care and the PHN region.
• Enhancing linkages between primary health care services, other providers and relevant services.
• Improving the patient journey and health outcomes.
• Increasing clinician capabilities and the quality of care provided.

Within the Country WA PHN (CWAPHN) region, the activity aims to:
• Develop, review, enhance and maintain aged care related content on the Clinician Assist WA website.
• Maintain relationship with the website developers to support the operation and administration of the Clinician Assist WA website.
• Increase the awareness of, engagement with, and utilisation of aged care related content on the Clinician Assist WA website.
• Increase awareness of and promote current best practice care for 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

Background
Clinician Assist WA content is developed, reviewed and enhanced as appropriate to meet the health needs of the PHN. Content is for use by clinicians during consultation with patients, supporting patient assessment and management, and referral to local services and supports.

Nineteen older adult and six dementia pathways are live and localised for WA and the CWAPHN region. One pathway was localised and six pathways were reviewed in 2022. Eleven pathways were reviewed in 2023 (two pathways were reviewed and merged into another pathway and the two standalone pathways were decommissioned). The review of the remaining seven pathways is planned for completion by 30 June 2025.

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. Moreover, geriatric syndromes later in life (usually after the age of 85 years) including pressure ulcers, incontinence, falls and delirium, have substantial implications for quality of life as well as health care utilisation.

In 2021, approximately 94,000 people aged 65 years and over lived in the CWAPHN region, representing about 17 per cent of its population, slightly higher than the state rate (Australian Bureau of Statistics, 2021a). This population is expected to increase by approximately 37 per cent to 117,882 in 2030.

Roles and responsibilities
WAPHA's Clinician Assist Team within the Primary Care Portfolio, which works across the three WA PHNs, is responsible for the delivery of the Aged Care Clinical Referral Pathways initiative. An executive sub-committee oversees all CWAPHN aged care activity, including the Aged Care Clinical Referral Pathways initiative, to ensure it aligns with funding requirements, guidance and WAPHA's Strategic Plan 2023-2026.

In addition to demonstration and education sessions led by the Clinician Assist Team, place-based integration managers and practice navigation and quality improvement teams also promote the use of the Clinician Assist WA website with general practice and relevant ACCHS staff. A program logic guides the initiative.

Key activities
This activity will:
• Increase the awareness of engagement with and utilisation of aged care related content on Clinician Assist WA by primary care practitioners and other clinicians within the regions.
• 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 and referral webpage development, enhancement, review and maintenance will include the following activities:
• Consultation with subject matter experts, peak bodies and clinicians.
• Mapping and documenting local support and referral services for the target population.
• Engaging with the website developers to ensure the website remains available, functional secure and maintained, and to provide technical support as required.
• Monitoring, reviewing and improving existing website content, ensuring currency, accuracy and consistency with best practice.
• Identification of any information gaps in the Clinician Assist WA library and consideration of new page developments, or incorporation of information into an existing page/s as required.
• Identification and inclusion of relevant resources for GPs and other health professionals to share with patients.
• Promoting newly published and/or reviewed pages to health professionals, in addition to delivering demonstrations and education to support the uptake of the Clinician Assist WA website.
• Maintaining the technical support agreement and relationship with the website developers to support the operation and administration of the Clinician Assist WA website.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support health and aged care providers in supporting older people live independently for as long as possible (Pilbara).	97
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Mid West).	73
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Goldfields-Esperance).	7
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (South West).	120
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Great Southern).	31

Activity Demographics

Target Population Cohort

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

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation has and will continue to 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), limited.
• Health service providers.
• WA Department of Health.
• Clinician Assist WA users.
• Other PHN regions across Australia.

The PHN promotes Clinician Assist WA to specific audiences at conferences (e.g., RACGP annual conference, Rural Health West Conference) and 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 Clinician Assist WA website and support users to maximise integration into their clinical practice.
• Launch new and newly reviewed Clinician Assist WA content , 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 and primary care interfaces.

Key stakeholders, in addition to those listed above include:
• Royal Australian College of General Practitioners.
• Subject Matter eExperts, including hospital clinicians, non-GP medical specialists, allied health practitioners, nurses, peak bodies (e.g., Diabetes WA, Trans, Gender Diverse and Non-Binary Health) to:
    o Collaborate on clinical and referral website content.
    o Provide representation and specialist expertise in working groups related to Clinician Assist WA development and/or review.

• Clinician Assist WA website developers.
The PHN is supported by and collaborates with the website developers who built the Clinician Assist WA website and now provide ongoing technical and website maintenance support.
• Other stakeholders as they are identified.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2025

Service Delivery Start Date

01/07/2022

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Seven Aged Care pages planned for/currently under review, with completion by 30 June 2025.

Activity Work Plans	Due 30/04/25
Annual Activity Needs Assessment	Due 15/11/24
Twelve Month Performance Report	Due 30/09/25
Financial Acquittal Report	Due 30/09/25

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
HealthPathways	$61,570.08	$76,250.46	$0.00	$0.00	$0.00	$137,820.54
Total	**$61,570.08**	**$76,250.46**	**$0.00**	**$0.00**	**$0.00**	**$137,820.54**

CF 2012 - Dementia Support Pathways

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

CF

Activity Number

2012

Activity Title

CF 2012 - Dementia Support Pathways

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Aged Care

Aim of Activity

In response to the Royal Commission into Aged Care Quality and Safety, Primary Health Networks (PHNs) are funded to undertake clinical and referral pathway activities specific to aged care and dementia.

The Dementia Clinical Referral Pathways activity will develop and enhance Western Australia's Primary Health Network's (PHNs) Clinician Assist WA 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 in the Country WA PHN (CWAPHN) region.

The activity is intended to:
• Improve dementia awareness within the PHN local community.
• Improve dementia knowledge within the primary care workforce to support clinicians in diagnosing, managing and referring people for diagnosis, and/or providing ongoing support at all stages of the dementia journey.
• Facilitate more timely diagnosis, including referral to diagnostic services.
• Enable earlier consumer access to post-diagnostic supports and services.
• Increase referrals from GPs to relevant post-diagnostic supports, such as Alzheimer's WA, Dementia Australia, My Aged Care, Carer Gateway, community support programs and services and allied health.
• Ensure that people with dementia, their family and carers are supported throughout the dementia journey.
• Maintain (where possible, improve) the quality of life for people with dementia, their family, and carers.

Description of Activity

Background
Clinician Assist WA content is developed, reviewed and enhanced as appropriate to meet the health needs of the PHN. Content is for use by clinicians during consultation with patients, supporting patient assessment and management, and referral to local services and supports.

The development and review of the WA Primary Health Alliance's (WAPHA's) Dementia Clinical and Referral Pathways (available on the Clinician Assist WA website) stream was completed on 20 December 2022. Pathways have since been maintained, publishing ad hoc updates as required, until their next scheduled formal review (scheduled to commence in 2026).

Rationale
In 2021, approximately 94,000 people aged 65 years and over lived in the CWAPHN region, representing about 17 per cent of its population, slightly higher than the state rate (Australian Bureau of Statistics, 2021a). This population is expected to increase by approximately 37 per cent to 117,882 in 2030.

It is estimated that in 2022, 37,963 people were living with dementia in WA, 7,948 lived in the CWAPHN region. The population of people with dementia is expected to continue to grow, and it is estimated that the number of people with dementia in Australia will more than double from 2022 (401,300) to 2058 (849,300).

Dementia is the second leading cause of death in Australia, and leading cause of death in women.

Early dementia diagnosis is essential in assisting people to live their best life through treatment of symptoms, early access to relevant health and support services, and planning. Evidence shows that early intervention can delay disease progression, minimise hospitalisations by coordinating care, improves the quality of life of the person living with dementia (and their carers/family) and delays entry to residential care.

Roles and responsibilities
WAPHA's Clinician Assist Team within the Primary Care Portfolio, which works across the three WA PHNs, is responsible for the delivery of the Dementia Clinical Referral Pathways initiative. An executive sub-committee oversees all CWAPHN aged care activity including the Dementia Clinical Referral Pathways initiative to ensure it aligns with funding requirements, guidance and WAPHA's Strategic Plan 2023-2026.

In addition to demonstration and education sessions led by the Clinician Assist Team, place-based integration managers and practice navigation and quality improvement teams also promote the use of the Clinician Assist WA website with general practice and relevant ACCHS staff. A program logic guides the initiative.

Key activities
From 2024 onwards CWAPHN will:
• Maintain the clinical dementia Clinician Assist WA content until next formal review.
• Update and maintain existing referral content, as new services for dementia care are established.
• Continue to promote and increase the awareness of, engagement with, and utilisation content related to of dementia found on the Clinician Assist WA website including consumer resources by local health care practitioners.
• Continue to work with Dementia Australia and Alzheimer's WA to ensure Clinician Assist WA content reflects emerging best practice and the available services and supports within the region.
• Continue to collaborate across PHN regions as required to support maintaining consistency and currency of content.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support health and aged care providers in supporting older people live independently for as long as possible (Pilbara).	97
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Mid West).	73
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Goldfields-Esperance).	7
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (South West).	120
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Support primary health care providers to promote healthy lifestyle changes and improve screening for chronic disease risk factors (Great Southern).	30
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Great Southern).	31
Support health and aged care providers in supporting older people live independently for as long as possible (Kimberley).	51

Activity Demographics

Target Population Cohort

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

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation from 2024 onwards will occur with the following key stakeholders (as required):
• 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
• Clinician Assist WA users
• Other PHN regions across Australia

The PHN promotes Clinician Assist WA to specific audiences at conferences (e.g., RACGP annual conference, Rural Health West Conference) and 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 Clinician Assist WA website platform and support users to maximise integration into their clinical practice.
• Launch new and newly reviewed Clinician Assist WA content, 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, other peak bodies (e.g., Dementia Support Australia) to:
    o Collaborate on clinical and referral website content.
    o Provide representation and specialist expertise in working groups related to Clinician Assist WA development and/or review.
• –Clinician Assist WA website developers.
• The PHN is supported by and collaborates with the website developers who built the Clinician Assist WA website and now provide ongoing technical and website maintenance support. Other stakeholders as they are identified.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2025

Service Delivery Start Date

01/07/2022

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Activity Work Plans	Due 30/04/25
Annual Activity Needs Assessment	Due 15/11/24
Twelve Month Performance Report	Due 30/09/25
Financial Acquittal Report	Due 30/09/25

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
HealthPathways	$15,392.52	$19,062.62	$0.00	$0.00	$0.00	$34,455.14
Total	**$15,392.52**	**$19,062.62**	**$0.00**	**$0.00**	**$0.00**	**$34,455.14**

CF 2020 - Dementia Consumer Pathway Resources

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

CF

Activity Number

2020

Activity Title

CF 2020 - Dementia Consumer Pathway Resources

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Aged Care

Aim of Activity

In response to the Royal Commission into Aged Care Quality and Safety, Primary Health Networks (PHNs) were funded to undertake a range of activities specific to aged care. This includes the development of Aged Care and Dementia Clinical Referral Pathways and the development and maintenance of dementia consumer resources.

This Activity Work Plan describes Country WA Primary Health Network's (CWAPHN's) approach to delivering the Dementia Consumer Resource activity.

The aim of the Dementia Consumer Resource activity is to enhance the ongoing care and support to people living with dementia, their carers, and families to support them to plan ahead and better navigate living with dementia, ultimately to support people living with dementia to live well in the community for as long as possible.

For the funding period, CWAPHN will develop and maintain consumer-focused dementia resource which details the post-diagnostic care and 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 developed 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.

Description of Activity

Background
In partnership with My Community Directory, WA Primary Health Alliance established the Dementia Community Services and Support Finder for the three WA PHNs. This resource tailored for individual regions, was published on 18 December 2022.

The development of the resource was informed by consultation with 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. Further consultation and promotion of the resource has occurred during 2023/24 and 2024/25

In March 2024, the Dementia support and services related information hosted by My Community Directory was moved to a WA Primary Health Alliance (WAPHA) Dementia consumer resources webpage. National, state, and local resources and service links continue to be available.

Rationale
In 2021, approximately 94,000 people aged 65 years and over lived in the CWAPHN region, representing about 17 per cent of its population, slightly higher than the state rate (Australian Bureau of Statistics, 2021a). This population is expected to increase by approximately 37per cent to 117,882 in 2030.

The Australian Institute of Health and Welfare reports:
• The rate of dementia rises quickly with age, from less than one person with dementia per 1000 Australians aged under 60 to 71 per 1000 Australians aged 75–79, and then to 429 per 1000 Australians aged 90 and over.
• Approximately 67 per cent of people with dementia live in the community.

It is estimated that in 2021, 37,963 people were living with dementia in WA, 7568 lived in the CWAPHN region and around 60 per cent were female. The population of people with dementia is expected to continue to grow, it is estimated that the number of people with dementia in Australia will more than double from the year 2022 (401,300) to the year 2058 (849,300).

Carers of people with dementia have consistently reported not knowing where to get assistance or what is the next practical step following a dementia diagnosis.

Roles and responsibilities
WAPHA's Primary Care Portfolio, which works across the three WA PHNs, is responsible for the delivery of the Dementia Consumer Resources via a dedicated activity lead. An executive sub-committee oversees all CWAPHN aged care activity including the Dementia Consumer Resources activity to ensure it aligns with funding requirements, guidance, and WAPHA's Strategic Plan 2023-2026.

Place-based regional integration managers and practice navigation and quality improvement teams promote the use of Dementia Consumer resources with clinicians and their local networks. A program logic guides the initiative.

In 2024 WAPHA partnered with Linkwest, the WA peak association for community resource centres, for Linkwest and their community resource centre members to review the webpage and provide information about any other related resources in their local communities. The webpage was then updated to include the additional support and referral resources.

Key activities
To the term of the funding CWAPHN will:
• Evaluate, maintain and where necessary improve / update relevant consumer resources.
• Monitor the use of the webpage.
• Continue to promote and increase the awareness, engagement and utilisation of dementia relevant consumer resources by local health care practitioners.
• Continue to promote the resource to people living in the PHN region and relevant forums.

• Work with Dementia Australia and other Primary Health Networks, where relevant, to ensure:
o Resources are updated in a nationally consistent manner.
o Continued access to Dementia Australia resources, via the WAPHA Dementia consumer resources webpage
• Continue to collaborate across PHN regions in sharing of consumer resource information.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30

Activity Demographics

Target Population Cohort

The target populations are:
• General practitioners, local primary care clinicians and allied health professionals
• People seeking advice about Dementia and the resources and services that are available to assist them.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation has occurred with and will continue to occur with the following key stakeholders (as required):
- Consumer representatives
- Carers Australia
- 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 Country Health Service
- Other PHN regions across Australia
- Linkwest and Community Resource Centres within the PHN region.

The Dementia Community Resources are promoted at relevant forums and via social media.

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 and primary care interfaces.

Collaboration has and will continue to occur (as relevant) with:
- Linkwest and community resource member organisations.
- Dementia Australia.
- Dementia Australia (WA).
- Alzheimer's WA.
- Other stakeholders as identified such as, providers of relevant services.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2025

Service Delivery Start Date

01/07/2022

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Activity Work Plans	Due 30/04/25
Annual Needs Assessment	Due 15/11/24
Twelve Month Performance Report	Due 30/09/25
Financial Acquittal Report	Due 30/09/25

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Dementia Consumer Pathway Resource	$10,258.06	$5,032.26	$0.00	$0.00	$0.00	$15,290.32
Total	**$10,258.06**	**$5,032.26**	**$0.00**	**$0.00**	**$0.00**	**$15,290.32**

CF 4000 - Healthy Weight

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

CF

Activity Number

4000

Activity Title

CF 4000 - Healthy Weight

Existing, Modified or New Activity

Modified

Activity Priorities and Description

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 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 2019-2024, 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.
• The use of Chronic Disease Management Plans via the Medicare Benefits Schedule (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 the WAPHA practice support team).
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 Clinician Assist WA , referral and management pathways for weight management for adults, childhood obesity and bariatric surgery.
3. General practice support includes:
• 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 2019-2024
• 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 function, which aims to allow integrated, coordinated overweight and obesity associated planning and action across WA.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary care to promote healthy weight and healthy lifestyle changes (South West).	118
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Pilbara).	96
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Goldfields-Esperance).	7
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Enable access to coordinated culturally appropriate primary care for Aboriginal people (South West).	119

Support primary care to promote healthy weight and healthy lifestyle changes (Goldfields-Esperance).	5
Enable access to best-practice management for people with coronary heart disease or chronic heart failure (Goldfields-Esperance)	5
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Mid West).	72
Support primary care to promote healthy weight and healthy lifestyle changes (Wheatbelt).	141
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Support primary care to promote healthy weight and healthy lifestyle changes, including smoking cessation (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Great Southern).	31
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Kimberley).	51

Activity Demographics

Target Population Cohort

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

Indigenous Specific

Yes

Indigenous Specific Comments

Stage 2 of the project involved the development of resources to add to the existing SHAPE website to assist healthcare professionals to support Aboriginal patients. This activity included consultation with Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Healthcare workforce and general practices. Collaboration with Diabetes WA for the development of educational videos to support General Practice in addressing weight management in Aboriginal populations across WA.

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

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 include the addition of resources 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 been completed, to inform Stage 2 deliverables. Consultation for Stage 3 was conducted from July 2024 - October 2024 to inform Stage 3 deliverables.

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. EMHS)
- 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
- WA Centre for Rural Health

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
- Health service providers (i.e. EMHS).
- WA general practices
- Royal Australian College of General Practitioners WA
- Diabetes WA
- Cancer Council WA
- Aboriginal Community Controlled Health Organisations
- Curtin University
- Benchmarque Group RTO

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2025

Service Delivery Start Date

01/07/2019

Service Delivery End Date

31/12/2025

Other Relevant Milestones

Stage 3 includes adding further resources to the SHAPE website, to assist health care professionals to support children living with overweight and obesity and their families living in Western Australia (July 2024 – December 2025).

- Activity Work Plans Due 30/04/25
- 12-month performance report Due 30/09/25
- Financial Acquittal Report Due 30/09/25

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Core Flexible	$57,427.00	$68,326.32	$0.00	$0.00	$0.00	$125,753.32
Total	**$57,427.00**	**$68,326.32**	**$0.00**	**$0.00**	**$0.00**	**$125,753.32**

CF 5000 - Strengthening General Practice; Comprehensive Primary Care

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

CF

Activity Number

5000

Activity Title

CF 5000 - Strengthening General Practice; Comprehensive Primary Care

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The Strengthening General Practice in WA; Comprehensive Primary Care (Strengthening General Practice) 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 aligned with the Quintuple Aim for Healthcare Improvement and the Bodenheimer Building Blocks for high performing primary care.

The activities delivered will utilise data driven quality improvements with a focus on enhanced leadership and team-based care which are:
• Patient centred – shared decision making that respects personal goals and provides support to patients to self-manage.
• Skilled, integrated and multi-disciplinary, where teams work to the top of their scope, in partnership with patients.
• Data informed, with embedded continuous quality improvement and best practice decision making to improve population health and access to care.
• Integrated wherever possible with allied health and the public and private hospital sector.
• Improved models of care and customer service encourage patient loyalty to their general practitioner and the practice maximising their care outcomes. Sustainable, utilising business models which are adaptable to changes in the health system and patient needs.

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.

Description of Activity

Background:
While Australia's primary healthcare system delivers some of the best health outcomes in the world, there are significant challenges if it is to remain viable, effective and efficient in meeting Australia's rapidly changing needs. Challenges include barriers to access for some groups in the community, in addition to rising costs to both system and consumers, an ageing population, increased rates of chronic disease, an over-reliance on hospital-based care and rising levels of inequality.

The Australian Primary Health Care 10 Year Plan 2022-2032 and the Strengthening Medicare Taskforce Report (2022) have both informed how WA Primary Health Alliance (WAPHA) continues to support general practices, with a focus on the ability of practices to adapt and respond to current and emerging health policy and reform in an effective and sustainable manner, in alignment with the Quintuple Aim.

In 2018 the Australian Government funded PHNs to support general practice staff and clinicians to provide high quality care for patients, particularly those at risk of poor health outcomes. The ongoing Commonwealth funding to support general practice has seen activities becoming iterative in nature, adapting to the maturation of general practices, and in response to the changing Australian primary health environment. WAPHA's support focuses on the ability of practices to adapt and respond to current and emerging health policy and reform in an effective and sustainable manner, in alignment with the Quintuple Aim.

Rationale:
The WAPHA Needs Assessment 2025-27 identified that people residing in CWAPHN have higher risk factors for developing chronic disease, higher rates of chronic disease and poorer outcomes than those living in either of the Perth Metropolitan PHN's. Specific regions in Country WA also have significantly higher rates of non-urgent emergency department presentations. The 2023 RACGP Health of the Nation findings indicate that patients living in or close to major cities visit their GP more frequently: almost eight services per patient in major cities, compared to 4.3 services per patient in remote areas. Additionally, wait times for a GP appointment are longer on average the further from a major city you live, with 50 per cent of people in outer rural and remote areas waiting 24 hrs or more for an urgent GP appointment.
These statistics are supported by the National Rural Health Alliances' Rural health in Australia Snapshot 2023, reporting that the further an Australian person lives from an urban centre, the lower their life expectancy. They are also twice as likely to die from preventable illness. This demonstrates an urgent need to address the inequalities in access to primary healthcare for Australians living in country WA.

Key activities:
The Strengthening General Practice funding enables WAPHA to continue to deliver and expand Comprehensive Primary Care and Enhanced practice support initiatives within the Country WA PHN.
- Utilising the Bodenheimer model 10 Building Blocks of high performing primary care to provide targeted, efficient activities, general practices will be supported to: Lead and develop practice teams to effectively engage in an evidence-based, phased process of practice transformation utilising Quality Improvement (QI) processes grounded in Institute for Healthcare Improvement (IHI) methodologies.
- Improve continuity of care with allied health tertiary and secondary services through integrated models of multi-disciplinary team-based care, data sharing, integrated care plans and specialist in-reach programs.

Have an opportunity to influence, co-design and trial models of care and incorporate existing local services that:
- Are integrated, local 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 continuity and coordination of care to improve health and social outcomes for patients.
- Build practices' capacity and capability to deliver responsive patient-centred care, which empowers patients to take an active role in the management of their own health.

• Promote both formal and informal collaboration opportunities to support knowledge sharing, professional development, problem-solving, and collegiality.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Kimberley).	50
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Mid West).	73
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Pilbara).	96
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (South West).	119
Improve the rates of cancer screening to reduce avoidable deaths from cancer (Goldfields-Esperance).	5
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Great Southern).	31

Activity Demographics

Target Population Cohort

Primary health provider organisations (including private general practice, ACCHO's, AMS's, allied health entities) located in identified priority areas of need and who are working with vulnerable populations, and the primary healthcare professionals engaged within these organisations.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Stakeholder engagement has been undertaken with:
- Previous naïve enquiry with primary care workforce.
- Regional and local primary care services including general practice
- Rural Health West.
- Consultation with WAPHA GP Advisory Panel.

Collaboration

Collaboration has occurred with:
- Private general practices, Aboriginal medical services
- General practitioners
- Practice managers
- Practice nurses
- Allied health providers
- Pharmacists
- Data officers – administrators
- Regional integration managers

Activity Milestone Details/Duration

Activity Start Date

31/12/2022

Activity End Date

29/06/2027

Service Delivery Start Date

1/07/2024

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25,30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due, 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Core Flexible	$200,000.00	$514,639.62	$229,325.76	$107,745.75	$0.00	$1,051,711.13
Total	**$200,000.00**	**$514,639.62**	**$229,325.76**	**$107,745.75**	**$0.00**	**$1,051,711.13**

GPIF 6000 - GP Incentive Fund - Kununurra - Phase 1

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

GPIF

Activity Number

6000

Activity Title

GPIF 6000 - GP Incentive Fund - Kununurra - Phase 1

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Workforce

Aim of Activity

The activity aims to:
• Identify barriers to accessing high quality general practice services within the Peel region
• Provide support and other incentives to attract and retain general practitioners (GPs) to areas of need
• Work with general practice within the Peel region to develop and implement longer term strategies around GP workforce
• Provide support and other incentives to upskill GPs in the region, to help meet local health needs.
The Peel region has had difficulty accessing GP services due to the lack of GPs and the difficulty in recruiting them since the regions MMM classification was changed from a 2 to a 1. This change resulted in the loss of access to Overseas trained GPs that were required to serve any sort of moratorium in a regional area MMM2-7.
The intended outcomes of this activity are to help increase the efficiency and effectiveness of the health care system and improve the health outcomes of the community in the Perth South PHN region by attracting additional GPs to the region but also by assisting to retain the current health workforce by offering them some incentives to stay. This may include some incentives to upskill in certain areas to be able to broaden the scope of their practice and offering to the local community.

Description of Activity

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

Following the successful implementation of activities during 2021-22, and 2022-23, activities planned for the 2023-24 period include:
2023-24
• Ongoing professional development, education and training activities to support the retention of GPs, practice managers and nurses. This will be delivered via Rural Health West and include the following activities:
o Chronic Conditions Evening education event and networking. This will be held in November 2023
o Mental Health Skills Training Workshop. This will be held in February 2024
o Peel GP Health Forum to be held in Mandurah in early June 2024
o RHW Education Grants which will assist GPs attend upskilling courses and conferences
o CPD support Subsidy for and array of upskilling courses
• Issue a final competitive grant round for selected practices to build upon their initial grant activities to recruit, retain or support their general practice workforce.

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

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers (incl. general practices, allied health and aged care services) to effectively manage chronic conditions for older people and promote health ageing at home(Metro)	54
Support primary health care providers to provide culturally appropriate chronic disease management for Aboriginal people living with chronic disease and build capacity for patient self-mgmt (Metro).	44

Activity Demographics

Target Population Cohort

General practices located in the Mandurah or Serpentine-Jarrahdale local government areas, with a view to improving access to primary care services for people living in the Peel region.

Indigenous Specific

No

Coverage

Whole Region

No

SA3 Name	SA3 Code
Mandurah	50201
Serpentine - Jarrahdale	50606

Activity Consultation and Collaboration

Consultation

The activity will be guided by the WAPHA Stakeholder Engagement Framework which has been developed by the organisation to set clear standards and expectations for staff and external stakeholders, including:
- South Metropolitan Health Service
- Royal Australian College of General Practice
- WA General Practice Education and Training
- Australian Medical Association
- Peel Health Campus (Ramsay Health)
- Peel Development Commission
- Peel Regional Development Australia
- Local Government (City of Mandurah, Shire of Murray, Shire of Waroona, Shire of Serpentine/Jarrahdale)
- Hunter New England Central Coast PHN
- Tasmania PHN
- Elected members of Parliament (State and Federal) inclusive of Hon. Member for Canning Andrew Hastie

Collaboration

Activities will occur with support from the following stakeholders:
- Rural Health West
- Nominated general practitioners and staff within the Peel Region

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Activity Milestone Details/Duration

Activity Start Date

14/06/2021

Activity End Date

29/06/2024

Service Delivery Start Date

15/06/2021

Service Delivery End Date

30/06/2024

Other Relevant Milestones

2023-24
- Delivery of a training and upskilling program through a Peel education and training support project commissioned through Rural Health West targeting GPs, Practice managers and nursing staff
- Awarding of additional competitive grant funds to successful general practices
- Final reporting and end of program 30/6/2024.

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): Yes
Other Approach (please provide details): No

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
PHN Program – General Practice Incentive Fund	$0.00	$35,535.00	$0.00	$0.00	$0.00	$35,535.00
Total	**$0.00**	**$35,535.00**	**$0.00**	**$0.00**	**$0.00**	**$35,535.00**

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

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

CF

Activity Number

6010

Activity Title

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

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The Medicare UCC policy was developed by the Australian Government to ease the pressure on hospital emergency departments and give Australian families more options to see a suitably qualified and skilled healthcare professional when they have an urgent but not life-threatening need for care. All Medicare UCCs are required to provide bulk-billed services, be open during extended business hours and accept walk-in patients for specified urgent care presentations.

In 2019 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 GPUCN.
The pilot ended in 2021.,

As of 29 January 2025, five practices were participating in the GPUCN in the Country WA PHN. Following the implementation of the Medicare UCC program and without additional funding, the GPUCN has transitioned to a business as usual (BAU) model.

To ensure the provision of high-quality urgent care to the WA community, the PHN offers Medicare UCCs and GPUCN practices access to urgent care training through registered training organisations.

This training is designed to enhance the skills of clinical staff, enabling them to deliver urgent care services that require specialised competencies beyond those typically found in mainstream general practice.

Description of Activity

To support the delivery of urgent care services, training will be commissioned for general practice staff. Training will be available for all UCC staff covering several key topics including:
• Splinting and immobilisation
• Triage – for frontline and clinical staff
• Intravenous (IV) Cannulation
• De-escalation
• Wound management

The Primary Health Network may also assist with printing of posters and signage to be displayed at local emergency departments promoting the UCC to encourage a change in patient behaviour and increased awareness of the alternative pathway.

The Primary Health Network (PHN) will continue to work with the existing GPUCN to understand the current capacity within the network and establish services to assist with reducing emergency department demand. The PHN will explore opportunities to 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.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Pilbara).	96
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Goldfields-Esperance).	7
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Enable access to coordinated culturally appropriate primary care for Aboriginal people (South West).	119
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Mid West).	72
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49

Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Great Southern).	31
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Kimberley).	51

Activity Demographics

Target Population Cohort

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

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The PHN has 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 has 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 emergency department diversion activities and initiatives such as the Virtual Emergency Medicine service, strengthen relationships with local hospitals and general practices to promote the GPUCN. 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.

Collaboration

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

WA Department of Health, Department of Health and Aged Care, Medicare Urgent Care Clinics and the GPUCN contribute to the design of the activity through feedback and data analysis on presentations to urgent care clinics and identifying skill gaps in clinic staff.
The Benchmarque Group as RTO design course content and relevant accreditation for delivery of procedural skills workshops.

Activity Milestone Details/Duration

Activity Start Date

31/12/2022

Activity End Date

29/06/2027

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27
Final Report	Due 30/09/27

Jan 2024 - Media campaigns developed in collaboration with WA Health and DHAC to ensure consistency in messaging and streamlined. Consider practice level social media tools for promotion of the clinic's services to their local community.

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Core Flexible	$62,500.00	$48,000.00	$30,000.00	$30,000.00	$0.00	$170,500.00
Total	**$62,500.00**	**$48,000.00**	**$30,000.00**	**$30,000.00**	**$0.00**	**$170,500.00**

HSI 1000 - Health System Improvement

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

HSI

Activity Number

1000

Activity Title

HSI 1000 - Health System Improvement

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

Health Systems Improvement funding is provided to enable Primary Health Networks (PHNs) 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.
• Assess and realise opportunities for joint commissioning arrangements with strategic partners.
• Determine health priorities and vulnerable cohorts, with the aim of improving access to primary care for those most at risk of adverse health outcomes.
• Progressively improve system performance, health outcomes and the quality and safety of primary care services.
• Ensure primary health care gains and potential are understood and utilised at regional, state, and national levels.
• Underpin PHN and government reform related decisions and activities with advanced digital health and data analytics capacity and governance structures that facilitate partnership approaches.
• Direct resources to where they are most needed and where they will have the greatest impact.

Description of Activity

WA Primary Health Alliance (WAPHA) is the operator of three Primary Health Network (PHN) regions - Perth North, Perth South, and Country WA. As a statewide agency, WAPHA is well positioned to systemically improve the quality, standard and connection of primary health care services across WA.
Strategic planning activities include:
• Leveraging WAPHA's statewide remit to consider and address system-wide issues of equity and access and progress actions to address local, regional, state, and national priorities.
• Understanding and interpreting Australian Government Guidance and health policy reform and translating it for application within the local primary health care context.

• Progressing the strategic objectives of the National Health Reform Agreement and 10-year primary health care plan by working with the state-funded health system to continuously improve health outcomes and address inequity in WA.
• Continued leadership of the national PHN Cooperative and collaboration with other PHNs to ensure collective value and impact is optimised and PHN effectiveness is enhanced through sharing models of care, learnings, and resources.
• Progression of PHN priorities for action in response to Strengthening Medicare Taskforce recommendations and ongoing strategic leadership as a member of the Taskforce.
• Demonstrating commitment to joint planning, shared accountability, and co-commissioning through formalised relationships with partners/system managers including the WA Mental Health Commission and health service providers.
• Working with other state-wide agencies, such as the Aboriginal Health Council of WA, Mental Health Commission and the Departments of Health and Communities to ensure that primary health care is appropriately represented to shape the direction of the WA health system and deliver better connected, patient-centred, high quality, innovative and sustainable care.
• Collaboration with training organisations, professional colleges, and health workforce agencies to plan for the future primary health care workforce and improve workforce capability.
• Cultivating local relationships and engaging with relevant stakeholders to coordinate care and develop pathways appropriate to local needs. This includes developing, trialling and evaluating integrated care precincts to attend to unmet need and reduce duplication, gaps and fragmentation in services.
• Planning, developing and maintaining agile, comprehensive, primary health care pandemic and disaster response and management capabilities and coordinating a strong primary health care response to deliver care where and when it is needed.
• Joint advocacy on behalf of primary health care stakeholders to influence primary health care reform and decision making.
• Leading the development of evidence based, innovative, best practice models of primary health care and evaluating initiatives against the Quintuple Aim.
• Developing the cultural competence and capability of WAPHA and commissioned primary health care services to better meet the needs of priority communities through the development and implementation of the Multicultural Competency and Capability Framework, the Aboriginal Cultural Competence and Capability Framework, and the LGBTIQA+ Equity and Inclusion framework.
• Managing and monitoring the performance of WAPHA team members to encourage ongoing improvement and continuous professional development, contributing to the maturity and functionality of the organisation.
• Articulate the role and scope of WA Primary Health Alliance in disaster and emergency management, and build capacity of general practice and commissioned service providers for business continuity and emergency preparedness and response.

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 Clinician Assist WA (previously HealthPathways 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 be most effective in collaboration with our external partners.
• Identifying priority populations to target for WAPHA's activities, including those experiencing economic disadvantage, Aboriginal people, Culturally and Linguistically Diverse (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.
• 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 expressions of interest (EOIs), requests for proposal and requests for tenders.
• Monitoring and review - outcome-based contracts and reporting are developed and implemented across WA Primary Health Alliance. The implementation of the Performance Management Framework will occur with clinical mental health services the first to get standardised mental health indicators followed by other programs such as drug and alcohol, Aboriginal health and chronic conditions.
• Evaluating - the performance of services is evaluated, and it is determined whether, and to what extent, a reshaping of the structure of supply is required.
The Country WA PHN continues to focus on managing performance (applying sound principles of relationship management) of contracted providers including reviewing/monitoring and evaluating services to determine how well targeted and efficient services are. It will achieve this utilising 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).

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to age-appropriate digital health services (Pilbara).	97
Enable access to age-appropriate digital health services (Mid West).	73
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Pilbara).	96
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Goldfields-Esperance).	7
Enable access to age-appropriate digital health services (Goldfields-Esperance).	7
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Enable access to coordinated culturally appropriate primary care for Aboriginal people (South West).	119
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Mid West).	72
Enable access to age-appropriate digital health services (South West).	120
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Wheatbelt).	142
Enable access to age-appropriate digital health services (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Enable access to mental health services (Great Southern).	30
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Great Southern).	31
Enable access to age-appropriate digital health services (Great Southern).	31

Enable access to coordinated culturally appropriate primary care for Aboriginal people (Kimberley).	51
Enable access to age-appropriate digital health services (Kimberley).	51

Activity Demographics

Target Population Cohort

• 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

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

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 Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2019

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): Yes
Other Approach (please provide details): No

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Health Systems Improvement	$3,628,604.78	$4,353,014.29	$3,788,653.54	$3,579,868.75	$0.00	$15,350,141.36
Total	**$3,628,604.78**	**$4,353,014.29**	**$3,788,653.54**	**$3,579,868.75**	**$0.00**	**$15,350,141.36**

HSI 1010 - General Practice Support

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

HSI

Activity Number

1010

Activity Title

HSI 1010 - General Practice Support

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

To build capacity and capability of WA general practice to work in an integrated manner within the primary health system and respond to Commonwealth Department of Health and Aged Care policy direction and reforms.
The activity includes two initiatives:
1. Support general practice staff, clinicians and other providers of primary health care to provide high quality and evidence-based care for their patients, including preventive and proactive activities with a focus on those at risk of poor health outcomes, to improve population health and equity of access.
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 and where appropriate in primary care. This encompasses multidisciplinary staff including general practitioners, practice managers, practice nurses, allied health practitioners and support staff.

Support to general practice staff and primary care
Support will be provided via several channels.
• The Practice Assist website (www.practiceassist.com.au) allows general practice staff to search through a comprehensive library of information, 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 Connect 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 one business day and more complicated queries within three business days, this may include liaising with subject matter experts within the Primary Health Network (PHN).
• Practice support staff regularly provide more in-depth support and coaching, centred around quality improvement and practice needs. They also provide and navigate to 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.
• Articulate the role and scope of WA Primary Health Alliance in disaster and emergency management, and build capacity of general practice and commissioned service providers for business continuity and emergency preparedness and response.
• Inform, educate, and utilise quality improvement tools to increase practice uptake of bowel, breast and cervical cancer screening programs, and interventions to improve childhood, Aboriginal, adolescent, and adult immunisation coverage
• Networking and education events are facilitated to allow practice managers and practice nurses to share lessons both of what works well and the challenges they experience. Updates re reforms and new information are also provided through these forums.
• Webinars and Community of Practice forums for general practitioners and other general practice staff around reforms and priority subjects identified by the PHN and general practitioners.
• Informing and updating practices on Commonwealth health policy initiatives such as Strengthening Medicare reforms (including MyMedicare), Practice Incentives Program (PIP) Quality Improvement (QI) incentive and Workforce Incentive Program (WIP) to support understanding and access.
• Connecting general practices with quality, evidence-based services to support their patient needs in their catchment areas, including WA Primary Health Alliance's commissioned services.
• Data analysis regarding the practices' screening targets and service delivery to enable their continuous improvement.
• Education on the use of Clinician Assist WA 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 challenges for vulnerable patient cohorts.

Data driven quality improvement
Enabling practice transformation will have a whole general practice approach to support data driven quality improvement 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) software at no cost to practices who have a data sharing agreement with the Primary Health Network.
• The business intelligence tool set will support general practices to make timely decisions regarding 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 ten (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 governance management capacity to protect the confidentiality, integrity, and accessibility of information, guided by the ISO/IEC 27001 Standard. This will be achieved by:
• Establishing an Information Security Management System in WAPHA in support of the ISO 27001 Certification.
• Embedding a risk-based approach to identify, detect, pre-empt and mitigate factors that compromise the confidentiality, integrity or availability of information.
• Embedding of ISMS related policies covering organisation, technological, People and Physical Controls.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Kimberley).	50
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Mid West).	73
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Pilbara).	96
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Pilbara).	96
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Goldfields-Esperance).	7
Support primary health care providers increase childhood immunisation rates overall, and deliver culturally appropriate & accessible vaccination programs for Aboriginal children (Goldfields-Esperance).	7
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (South West).	119
Enable access to coordinated culturally appropriate primary care for Aboriginal people (South West).	119
Improve the rates of cancer screening to reduce avoidable deaths from cancer (Goldfields-Esperance).	5
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Mid West).	72
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Wheatbelt).	142
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49

Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Great Southern).	31
Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children (Great Southern).	31
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Kimberley).	51

Activity Demographics

Target Population Cohort

General practice and the primary health sector

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Stakeholder engagement has occurred with:
- Primary care workforce.
- Regional and local primary care services including general practice.
- Rural Health West.
- Consultation with WAPHA GP Advisory Group.

Collaboration

Collaboration has occurred with:
- Private general practices, Aboriginal medical services
- General practitioners
- Practice managers
- Practice nurses
- Allied health providers
- Pharmacists
- Data officers – administrators
- Regional integration managers

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2019

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Health Systems Improvement	$382,373.32	$393,831.21	$331,034.09	$331,034.09	$0.00	$1,438,272.71
Total	**$382,373.32**	**$393,831.21**	**$331,034.09**	**$331,034.09**	**$0.00**	**$1,438,272.71**

HSI 1020 - Clinician Assist WA

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

HSI

Activity Number

1020

Activity Title

HSI 1020 - Clinician Assist WA

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The Country WA PHN aims to:
• Develop , enhance, maintain, and promote Clinician Assist WA - a website containing information targeted at general practitioners (GPs), (and other health professionals), providing best practice clinical guidance and local patient referral information specific to WA. The result is patient care that is well coordinated, efficient and effective.
• Develop and deliver targeted demonstrations and activities, supporting the awareness of, engagement with and utilisation of Clinician Assist WA and how to maximise integration into practice.

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

Clinician Assist WA supports a multidisciplinary approach to patient care, providing information to GPs (as the primary target audience), and other healthcare professionals (including primary care clinicians and allied health professionals).

The Clinician Assist WA team works collaboratively with Health Service Providers, the WA Department of Health, Subject Matter Experts (SMEs), peak bodies and consumers (limited), in addition to general practice, to inform the resulting clinical and referral content. This collaboration also contributes towards population health planning through the identification and escalation of care and service gaps.

Description of Activity

Clinician Assist WA provides high quality, evidence based, clinical and referral guidance for clinicians working in general practice to reference during patient consultations.

The Clinician Assist WA team consists of clinical editors who are supported by coordinators and a leadership team. The team develops, reviews and maintains content, and develops and delivers educational events and materials related to Clinician Assist WA.

The main activities of the team include:
• Identifying, prioritising, and developing new clinical (and non-clinical) and Referral pages.
• Administering and maintaining the Clinician Assist WA website.
• Reviewing and maintaining existing content.
• Mapping services and incorporating them into new and existing pages
• Facilitating multi-disciplinary working groups which inform website content and identify care and service gaps for escalation.
• Facilitating consultation activities in conjunction with the WA Department of Health – Health Networks.
• Preparation and delivery of reports related to engagement and usage.
• Demonstrating the use of and providing targeted education about how to maximise the integration of Clinician Assist WA into clinical practice.
• Facilitating Clinician Assist WA promotional activities.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Mid West).	73
Support primary care to promote healthy weight and healthy lifestyle changes (South West).	118
Support General Practices in identifying people at risk of suicide and referring to appropriate services, including telehealth mental health providers (South West).	118
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Goldfields-Esperance).	7
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Support primary care to promote healthy weight and healthy lifestyle changes (Goldfields-Esperance).	5
Improve the rates of cancer screening to reduce avoidable deaths from cancer (Goldfields-Esperance).	5
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (South West).	120
Support primary care to promote healthy weight and healthy lifestyle changes (Wheatbelt).	141
Support General Practices in identifying people at risk of suicide and referring to appropriate services, including telehealth mental health providers (Wheatbelt).	141

Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Wheatbelt).	142
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support General Practices in identifying people at risk of suicide and referring to appropriate services, including telehealth mental health providers (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible (Great Southern).	31

Activity Demographics

Target Population Cohort

General practitioners are the primary audience of this activity, in addition to clinicians working in/supporting the provision of primary healthcare (e.g., practice nurses, allied health professionals) practicing in the Country WA PHN.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The PHN engages numerous stakeholders to support progression of the Clinician Assist WA Program including:
- WA Department of Health
- Health Service Providers (HSPs)
- Clinician Assist WA Users
- General practitioners and other primary health professionals
- Other PHNs across Australia

The PHN promotes Clinician Assist WA to specific audiences at conferences (e.g. RACGP annual conference, 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 demonstrations related to Clinician Assist WA to clinicians working in general practice, primary care and other services as relevant.

Collaboration

The PHN collaborates with the following stakeholders to support progression of the Clinician Assist WA Program:
• WA Department of Health.
• Royal Australian College of General Practitioners.
• Subject Matter Experts (SMEs) including hospital clinicians, non-GP medical specialists, allied health practitioners, nurses etc.)
• Consumer representatives, GPs, health service providers, peak bodies (e.g., Diabetes WA, Australasian Society of Clinical Immunology and Allergy (ASCIA)) to:
o Inform clinical and referral website content.
o Provide representation and specialist expertise in working groups related to Clinician Assist WA content development and/or review.
Clinician Assist WA website developers. The PHN is supported by and collaborates with the website developers who built the Clinician Assist WA website and now provide ongoing technical and website maintenance support.
• Other stakeholders as they are identified.

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2019

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/25
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/26
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/26

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Health Systems Improvement	$112,960.09	$116,344.96	$97,793.54	$97,793.54	$0.00	$424,892.13
Total	**$112,960.09**	**$116,344.96**	**$97,793.54**	**$97,793.54**	**$0.00**	**$424,892.13**

HSI 2000 - Stakeholder Engagement and Communication

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

HSI

Activity Number

2000

Activity Title

HSI 2000 - Stakeholder Engagement and Communication

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

Communications and stakeholder engagement activities aim to establish and nurture strong and meaningful purposeful relationships with the diversity of stakeholders in primary care.

Establishing and maintaining trusting and purposeful relationships is essential to achieving our vision of better health, together.
The strength of our relationships with stakeholders enables us to work collaboratively with others and to engage a diversity of knowledge, skills and experience through all aspects of commissioning and practice improvement.

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

Description of Activity

Communications and Marketing
The communications team 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: undertake planned and deliberate activities to market and communicate our purpose, work and value.
• Brand management: build and maintain a consistent corporate image.
• Media relations: facilitate favourable (where possible), accurate and timely media coverage.

• Government relations: inform elected members about the work of the PHN via in person visits and information packs.

• Issues Management: identify and manage contentious issues/protect WAPHA's reputation.
• Internal communications: facilitate the delivery of information and encourage two-way conversation to engage team members and help them do their jobs.

Priorities to 2025 to 2026 include:
• Strategic communications approaches and key messages to align with the WA Primary Health Alliance Strategic Plan 2023 – 2026 to reach our priority stakeholders and those with a latent or emerging interest in our work to ensure they understand how we are adding value to the WA and, as the lead PHN for national programs, the national health system.
• Continuing to build our audiences and communicate with them in an increasingly targeted way, consistently using segmentation and tailored messaging, and using performance metrics to continuously refine our communication approach and channels.
• Embedding culturally inclusive language and images across our communication platforms to demonstrate WAPHA's leadership in culturally safe and inclusive practice.
• Maturing the way in which we demonstrate innovation, value to the community and the overall return on investment of the PHN program in WA.

Stakeholder Engagement
Stakeholder engagement plays a critical role in ensuring WAPHA understands and listens to key stakeholders across local community, health care providers, and Government and other entities. WAPHA's stakeholder engagement aligns to best practice IAP2 international stakeholder engagement methodology allowing WAPHA to build and maintain a holistic understanding of our region's unique health care needs.

WAPHA's Stakeholder Engagement team's purpose is to lead the organisation in implementing quality improvement initiatives, exemplary partnerships, and stakeholder relationship management system capability, by empowering employees to achieve best practice stakeholder engagement aligned with PHN strategic priorities.

The Stakeholder Engagement team will continue to:
• Lead and coordinate strategies, projects and activities that maintain the integrity of stakeholder engagement approaches across WAPHA.
• Build engagement capacity of employees 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.

Specific activities include:
WA GP Advisory Panels – a partnership with Rural Health and Royal Australian College of General Practitioners (RACGP) WA to directly engage general practitioners (GPs). WAPHA has a membership database of GPs across the state who register for evening online panel meetings where topics relevant to primary health care are discussed and GPs opinion, insight and expertise is canvassed. Summary papers are drafted following the meetings, with ideas and recommendations shared.

Commissioned Service Provider Panels – WAPHA's commissioned service provider chief executive officers (CEOs) who have registered to be a member of the panel are invited to discuss key issues regarding relevant topic areas with insight, recommendations and summaries provided for action.

WAPHA Organisational Members – key partner organisations enabling co-funding and primary health care influence across WA. Organisational members include WA Department of Health, Mental Health Commission, WA

Council of Social Services, Rural Health West, RACGP WA, Australian College of Rural and Remote Medicine, Health Consumers' Council and WA Local Government Association. Members meet with and present to the WAPHA Board as well as attend regular meetings with WAPHA Executive Team.

Stakeholder Relationship Management system – a Microsoft Dynamics 365 CRM platform to digitally record and capture stakeholder engagement within the WAPHA team. The system includes – CRM Hub, Customer Voice, Marketing and Events modules to systematically engage with stakeholders.

WAPHA Board Sub-Committee – Strategic Engagement Advisory Committee – board member subcommittee committed to governance assurance for stakeholder engagement across WAPHA.

Health Professionals Network – statewide partnership with Rural Health West and WA Country Health Service to foster education and engagement amongst clinician working in regional WA.

Reference Groups – formal membership for LGBTIQA+ Reference Group and Multicultural Reference Group. Expression of Interest for development of an Aboriginal Stakeholder Reference Group.

Priorities 2025 to 2026 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 WAPHA's Stakeholder Engagement Framework, with an emphasis on our digital enablers, including WAPHA's Dynamics 365 Stakeholder Relationship Management digital platform and stakeholder sentiment.
• Ongoing development of the WA GP Advisory Panel, in partnership with Rural Health West and RACGP (WA), to enable external partners to engage with general practitioners in operational and strategic directions setting and policy implementation.
• Maturing partnerships with strategic stakeholders.
• Implementation of WAPHAs LGBTIQA+ Equity and Inclusion Framework as it aligns to Rainbow Tick accreditation.
• Implementation of WAPHA's Aboriginal Cultural Competency and Capability Framework as it aligns to our Innovate RAP.
• Implementation of WAPHA's Multicultural Framework as it aligns to our multicultural needs assessment.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to culturally appropriate mental health care and early intervention suicide prevention services, including for young people (South West).	118
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95

Enable access to culturally appropriate mental health and early intervention suicide prevention services and support primary health care providers in identifying people at risk (Pilbara).	95
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Enable access to culturally appropriate mental health care and early intervention suicide prevention services, including for young people (Wheatbelt).	141
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Enable access to culturally appropriate mental health and early intervention suicide prevention services and support primary health care providers in identifying people at risk (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30
Enable access to culturally appropriate mental health and early intervention suicide prevention services and support primary health care providers in identifying people at risk (Great Southern).	29

Activity Demographics

Target Population Cohort

The target population of this activity will include Country WA PHN stakeholders, including general practices, commissioned service providers, government entities, health service providers (hospitals and community health), health, welfare and community service providers (including the Aboriginal sector), community, consumer and carer groups.

Indigenous Specific

Yes

Indigenous Specific Comments

As well as engaging with commissioned service providers which are Aboriginal owned and operated, WAPHA has ongoing engagement with the state's peak Aboriginal organisation and is seeking to stand up an Aboriginal Stakeholder Reference Group. Numerous commitments and activities are documented in our Aboriginal Cultural Competency and Capability Framework, aligning with our Innovate RAP. Additionally, guided by our Welcome to Country and Acknowledgment of Country Policy, we regularly engage with Aboriginal people across the state and acknowledge the Traditional Owners of the lands upon which we work.

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

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 RACGP WA and Rural Health West. RACGP make an in-kind contribution by administering payment to GPs, and all partners play an equal role in setting agendas and actioning comments raised by members.

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2019

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/25
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): Yes
Other Approach (please provide details): No

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Health Systems Improvement	$200,586.91	$206,597.54	$173,655.17	$173,655.17	$0.00	$754,494.79
Total	**$200,586.91**	**$206,597.54**	**$173,655.17**	**$173,655.17**	**$0.00**	**$754,494.79**

HSI 4000 Emergency Preparedness and coordination

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

HSI

Activity Number

4000

Activity Title

HSI 4000 Emergency Preparedness and coordination

Existing, Modified or New Activity

New Activity

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The introduction of Emergency preparedness and coordination funding under the Health System Improvement stream of the PHN Core Funding Schedule allows WA Primary Health Alliance (WAPHA) to build capacity of primary care to manage emergency preparedness, planning and coordination functions in Country WA PHN by:
• Preparing and maintaining emergency preparedness protocols.
• Updating protocols annually in line with Emergency Preparedness Policy Guidelines provided by the Department of Health, Disability and Ageing (DHDA).
• Engaging regularly with local and district stakeholders relating to emergency preparedness, planning, response, and recovery.
• Integrating and coordinating health services in Country WA PHN regions to prepare for the event of a natural and/or health emergency situation.
In Country WA PHN, WAPHA staff will engage with key local and district stakeholders engaged in emergency response and management, as well as primary health providers to support emergency preparedness and response.
These activities will be undertaken with a focus on general practices and locations which are under-resourced and where there are higher cohorts of people who are hard-to-reach, have inadequate access to primary health care and are most at risk of poorer health outcomes.

Description of Activity

Background
In February 2020 in response to the extreme bushfire season of 2019-2020, which resulted in loss of life, property, wildlife and environmental destruction, a Royal Commission into Natural Disaster Arrangements was established.

The subsequent report recommended that Australian state and territory governments should develop arrangements that facilitate greater inclusion of primary healthcare providers in disaster management, including representation on relevant disaster committees and plans and providing training, education and other supports (Recommendation 15.2).
Joint planning and funding at a local level, including strengthening coordination between Local Health Networks (LHNs) and PHNs is a key reform priority of the National Health Reform Agreement NHRA 2020-25 Addendum , an agreement between Australian, state and territory governments to improve health outcomes for all Australians and ensure our system is sustainable.
The Department of Health, Disability and Ageing (DHDA) Australia's Primary Health Care 10 Year Plan 2022–2032 also identifies that the PHNs have played a vital role in supporting the primary care response through the droughts, bushfires and COVID-19 pandemic of recent years, and seeks to integrate and embed primary health care as a natural and critical part of emergency preparedness and response structures at regional, state and national levels.
Rationale

Primary health care is recognised as an essential and critical part of the health system. Access to these services is relied upon by communities, and building the capacity and capability of these providers to continue to operate during a disaster or emergency is of significant importance. Business as usual is always disrupted during and immediately after disasters or emergencies, however adequate planning and testing of alternative operating arrangements, as well as improving coordination and integration with other local health services will improve the ability of these services to continue to provide essential health care to communities at times of need and severely limited resources.

Roles and Responsibilities
To maintain feasibility and sustainability, delivery will draw on in-kind support from the Primary Care and Commissioned Services portfolio. An executive sub-committee will oversee this activity to ensure it aligns with funding requirements and guidance, and WAPHA's Strategic Plan 2023-2026.
Activities will be undertaken by key functions including primary care engagement, learning and development, regional integration and contract and procurement.
Key Activities
WAPHA will scope and sequence delivery in a manner commensurate with funding allocated, ensuring efforts are proportionate and directed towards high-impact deliverables. Where possible, activities will be integrated into existing WAPHA systems, regional structures and stakeholder relationships to optimise available resources.
Key activities for Country WA PHN include:
• PHN engagement in the Local and District Emergency Management Committees
• Support integration of local services and resources to build capacity to respond to emergencies
• Promotion and publication of best practice emergency preparedness guidelines
• Embedding emergency management requirements as a meaningful and proportionate component of procurement, commissioning and contract management.
• Dissemination of DHDA and WA Health provided emergency and disaster information via established and appropriate communication channels
• Promotion of best-practice tools and resources to support primary health care organisations to prepare and respond to emergency situations
• Promotion of disaster and emergency education and training
Performance measures will be achieved in a proportionate manner that reflects the scale of available funding and will prioritise high-need or disaster-prone regions as identified.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Pilbara).	96
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Goldfields-Esperance).	7
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Enable access to culturally appropriate mental health and early intervention suicide prevention services and support primary health care providers in identifying people at risk (Pilbara).	95
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Enable access to culturally appropriate mental health and early intervention suicide prevention services and support primary health care providers in identifying people at risk (Kimberley).	49

Activity Demographics

Target Population Cohort

Primary health care organisations including general practices, Aboriginal Community controlled Health Services (ACCHS) and commissioned service providers in Country WA.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

A separate and discretely funded activity that WAPHA has been undertaking related to the role of general practice in the emergency response has several points of alignment with this activity. Stakeholder consultation undertaken through this activity in 2024 is applicable and aligns to the development of the activities outlined in this AWP.
Further consultation with WA Health, RACGP, general practices and ACCHS will be undertaken as required.

Collaboration

- General practices and other primary health care providers
- Aboriginal Community Controlled Health Services
- Commissioned Service Providers
- WA Health
- Local Government Agencies

Activity Milestone Details/Duration

Activity Start Date

30/06/2025

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2025

Service Delivery End Date

30/06/2027

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: Yes
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Health Systems Improvement	$0.00	$0.00	$17,073.68	$104,707.44	$0.00	$121,781.12
Total	**$0.00**	**$0.00**	**$17,073.68**	**$104,707.44**	**$0.00**	**$121,781.12**

CF 8010 - COVID-19 Primary Care Support

Activity Metadata

Applicable Schedule

Core Funding - Country WA

Activity Prefix

CF-COVID-PCS

Activity Number

8010

Activity Title

CF 8010 - COVID-19 Primary Care Support

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The activity aims to provide support for Australia's COVID-19 Vaccine and Treatment Strategy to the primary, aged care and disability sectors within the Country WA 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 general practices, Aboriginal Community Controlled Services, residential aged care facilities (RACF), disability accommodation facilities and governments on local needs and issues.
• Strengthen relationships within RACFs by providing support to coordinate vaccination services, promoting collaboration through educational initiatives, and ensuring residents and staff have efficient access to vaccinations. Supporting vaccine delivery sites in their operation and ongoing quality control.
• Provide guidance and support to increase the COVID 19 vaccination program for vulnerable populations identified through data analysis and stakeholder engagement.
• 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.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (South West).	118
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Pilbara).	95
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Goldfields-Esperance).	5
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Wheatbelt).	141
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Kimberley).	49
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Mid West).	71
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management (Great Southern).	30

Activity Demographics

Target Population Cohort

Primary health, aged care, and disability sectors

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The PHN consulted with and continues to engage with a range of stakeholders to support primary care providers including but not limited to:
- Department of Health and Aged Care
- Other PHNs
- General Practices

- WA Department of Health including public health units
- 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 WA Department of Health, general practitioners, community organisations, Aboriginal community controlled health organisations, residential aged care facilities, pharmacies and other agencies to support provision of vaccinations to 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 Milestone Details/Duration

Activity Start Date

08/09/2021

Activity End Date

30/12/2025

Service Delivery Start Date

09/09/2021

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Activity Work Plans	Due 30/04/25
Twelve Month Performance Report	Due 30/09/25
Financial Acquittal Report	Due 30/09/25

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
COVID-19 Primary Care Support	$436,944.00	$682,493.01	$137,720.00	$0.00	$0.00	$1,257,157.01
Total	**$436,944.00**	**$682,493.01**	**$137,720.00**	**$0.00**	**$0.00**	**$1,257,157.01**