WA Primary Health Alliance PHN Aged Care Perth North 2024/25 - 2027/28 Activity Summary View

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

T 08 6272 4900 F 08 9277 5304 E info@wapha.org.au A level 2, 1 Hood Street Subiaco 6008 PO Box 883 Subiaco 6904 ABN 11 602 416 697

/waphaphns /wapha_phns /wapha_phns www.wapha.org.au

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AC-VARACF 1000 - SUPPORT RACF'S TO INCREASE AVAILABILITY AND USE OF TELEHEALTH CARE FOR AGED CARE RESIDENTS

ACTIVITY DETAILS

Activity Reference:	AC-VARACF
Activity Number:	1000
Status:	Existing
PHN Program Key Priority Area:	Aged Care

ACTIVITY AIM & OBJECTIVES

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

PNPHN will:

- Assist participating RACFs in the PHN region, to build telehealth capability with equipment that has been provided by the PHN, to enable residents to virtually consult with primary health care professionals.
- Provide training to participating RACF staff so they have the capabilities to assist residents in accessing virtual consultation services.
- Provide training and support to General Practice staff to support the provision of virtual care services for residents in aged care homes.
- Promote the use of enablers of digital health, such as My Health Record (MHR) and the electronic national residential medication chart (eNRMC) to improve the availability and secure transfer of resident's health care information between the RACF, primary care and acute care settings.
- Consult with key stakeholders to improve technological interoperability between the aged care and health care systems.

DESCRIPTION OF ACTIVITY

Background

The GEN Aged Care Data Service list identifies 103 RACFs in PNPHN at 30 June 2024 (latest data available).

PNPHN has a slightly higher rate of permanent residential aged care recipients per 1000 target population (58.9%) compared to the state (55.8%) with 89% residential care occupancy rate. Many residents have complex health conditions, atypical symptoms, and multiple comorbidities. Their health can deteriorate rapidly. More than half (59%) of people using permanent residential aged care in the PHN had a diagnosis of dementia[1]. Ref: [1]PNPHN Needs Assessment 2025-2027.

Rationale

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

Telehealth can address barriers to providing and accessing high quality healthcare in RACFs. It can also provide access to services that may not be available locally, preventing the need for residents to travel and avoiding the negative impacts of removing residents from their home environment for avoidable hospital visits. Telehealth can also assist in reducing the exposure of residents to communicable diseases and infections.

Roles and Responsibilities

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

A small team, consisting of an activity lead and Digital Health Officers lead the *RACF Telehealth* activities across the three WA PHNs. Contract managers, place-based integration managers, and training and practice support staff assist the team. A program logic guides activities.

Key activities

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

Following feedback from RACFs, WAPHA commissioned Visionflex to deploy batteries to further enhance the capabilities of the telehealth carts.

WAPHA will undertake a range of activities to build telehealth capability with RACHs that have received PHN provided equipment, these RACHS are referred to as participating RACFs.

For RACFs participating in the activity WAPHA will:

- Provide advice to RACFs to encourage compatibility with virtual consultation technology used in the region, guided by recognised standards.
- Seek feedback from RACFs to measure telehealth capabilities, use of MHR, access to GPs and relevant training needs.
- Provide hardware and software training, technical support, and resources to participating RACFs and health professionals to build telehealth capability.
- Encourage RACFs to establish telehealth champion roles who provide on the ground training and troubleshooting when required and facilitating networking between the champions to promote shared problem solving and sharing of information related to models of care and lesson learnt.
- Assist RACFs with telehealth abilities and equipment to enable residents access to remote consultations, including the development and implementation of telehealth implementation plans.
- Facilitate engagement between RACF and primary care providers and supporting the creation of replicable appointment pathways.
- Provide a digital quality improvement package.

- Promote MHR, providing education to RACF staff on the adoption and use of MHR and aiding with registration where required.
- Promote the eNRMC and support RACFs to access appropriate training and support from software vendors.
- Provide training and support to primary health care providers on the effective use of telehealth and associated digital tools.

For non-participating RACFs, WAPHA will:

- Follow up with non-participating RACFs to promote the use of telehealth in RACFs.
- Offer a digital quality improvement package.
- Promote MHR, providing education to RACF staff on the adoption and use of MHR and aiding with registration where required.
- Promote the eNRMC and support RACFs to access appropriate training and support from software vendors.
- Provide training and support to primary health care providers on the effective use of telehealth and associated digital tools.

Communication and engagement – WAPHA will:

- Share relevant WA Health, and North and East Metropolitan Health Services virtual service information, and other related activity information with RACFs via WAPHA's Newsletters.
- Continue consultation and engagement with WA Health, and North and East Metropolitan Health Services to ensure PNPHN activities do not duplicate efforts underway to improve technological interoperability between aged care and health systems.
- Continue collaboration with other stakeholders throughout the activity to encourage the implementation of telehealth services in RACHs.
- Provide regular progress updates to primary care providers in the region to promote the availability of RACF telehealth capabilities.
- Identify and promote case studies demonstrating the benefits of telehealth.
- Identify and promote lessons learnt from RACFs and primary care providers on the implementation and ongoing use of telehealth.

Contract and relationship management, WAPHA will:

- Establish an agreement with participating RACFs and maintain oversight so that agreed activities are undertaken.
- Manage unspent funds in accordance with the funding guidance.

Reporting – WAPHA will:

- Complete reports as per the executed WAPHA and Department of Health, Disability and Ageing agreement variation.

PHN NEEDS ASSESSMENT PRIORITIES

- Enable access to after-hours primary health care.
- Enable access to age-appropriate digital health services.

POPULATION & COVERAGE

TARGET POPULATION:

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

INDIGENOUS SPECIFIC

Will this activity target Aboriginal population? No

ACTIVITY CONSULTATION & COLLABORATION

CONSULTATION

- Residential Aged Care Facilities
- Royal Australian College of GPs (WA)
- Ageing Australia representatives.
- General Practitioners
- WA Department of Health Aged and Community Policy Team.
- Department of Health, Disability and Ageing's Local Network team
- WA Health Virtual Emergency Department
- East Metropolitan Health Service (EMHS) Community Health in a Virtual Environment (Co-HIVE) Aged Care Service
- North Metropolitan Health Service (NMHS) Emergency Care Navigation Centre (ECNC)

COLLABORATION

PNPHN will invite RACFs to participate in RACF Telehealth activities.

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

ACTIVITY MILESTONES AND DURATION

Activity Start Date:	3/05/2022
Activity End Date:	30/06/2027

MILESTONES

Activity Work Plan	Due:	28/05/25, 30/04/26, 30/04/27
Annual Needs Assessment	Due:	15/11/25, 15/11/26
12-month Performance Report	Due:	30/09/25, 30/09/26, 30/09/27
Final Performance Report	Due:	30/09/27

SERVICE DELIVERY DURATION

Service Delivery Date: 1/04/2022

Service Delivery End Date: 30/06/2027

COMMISSIONING APPROACH

Select the commissioning approach:

Continuing Service Provider

Tender for TH equipment provider.

ACTIVITY PLANNED EXPENDITURE

	FY 24-25	FY 25-26	FY 26-27	FY 27-28
Virtual Access Operational	$227,741.13	$199,190.51	$202,578.25	$0.00
Total	**$227,741.13**	**$199,190.51**	**$202,578.25**	**$0.00**

AC-AHARACF 2000 - ENHANCED AFTER HOURS SUPPORT FOR RESIDENTIAL AGED CARE FACILITIES

ACTIVITY DETAILS

Activity Reference:	AC-AHARACF
Activity Number:	2000
Status:	Existing
PHN Program Key Priority Area:	Aged Care

ACTIVITY AIM & OBJECTIVES

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

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

The intended outcome of this activity is to help reduce unnecessary hospital presentations among RACF residents by:

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

DESCRIPTION OF ACTIVITY

Background

The GEN Aged Care Data Service list shows that there were 103 RACFs in PNPHN at 30 June 2024.

PNPHN has a slightly higher rate of permanent residential aged care recipients per 1000 target population (58.9%) compared to the state (55.8%) with 89% residential care occupancy rate. Many residents have complex health conditions, atypical symptoms, and multiple comorbidities. Their health can deteriorate rapidly. More than half (59%) of people using permanent residential aged care in the PHN had a diagnosis of dementia1. Ref: 1PNPHN Needs Assessment 2025-2027.

Rationale

Research shows that substantial emergency department (ED) demand comes from patients living in RACFs. Residents can experience rapid health deterioration during the after-hours period, however immediate transfer to hospital is not always clinically necessary.

Lack of awareness and utilisation of after-hours services provided by GPs and other health professionals can lead to unnecessary ED presentations and hospitalisations. Potentially Preventable Hospitalisation (PPH) data for 2017-18, identifies that 46% of all PPHs across Australia were for people aged 65 and over.

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

Roles and responsibilities

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

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

Key activities

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

PNPHN will:

<u>Communication and engagement</u>

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

<u>Resource development and education</u>

- Seek advice from RACF representatives about what resources are required and their design.
- Seek feedback from RACF representatives to support ongoing maintenance and updating of the after-hours planning resources.
- Review and update the after-hours action planning resources to assist RACFs to develop and regularly update after-hours action plans and processes.
- Undertake an environmental scan to understand which services are available after-hours and share the information with RACFs.
- Encourage RACFs to work with residents so that after-hours wishes are included in residents' advanced care plans.

For participating RACFs

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

For non-participating RACFs

- Promote this initiative via WAPHA's Aged Care Connect newsletters and website and encourage their engagement in the development of after-hours action plans.

Reporting

- Complete reports as per the executed agreement variation.

PHN NEEDS ASSESSMENT PRIORITIES

- Enable access to after-hours primary health care.
- Enable access to age-appropriate digital health services.

POPULATION & COVERAGE

TARGET POPULATION:

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

INDIGENOUS SPECIFIC

Will this activity target Aboriginal population? No

ACTIVITY CONSULTATION & COLLABORATION

CONSULTATION

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

- RACFs
- WA Department of Health, Aged Care Directorate
- WA Department of Health, WA Virtual ED Project Team
- Residential Care Line Outreach Service
- North Metropolitan Health Service
- East Metropolitan Health Service
- Royal Australian College of General Practitioners.
- General Practitioner representatives.
- Ageing Australia
- Department of Health, Disability and Ageing's Local Network team

This engagement will continue as required.

COLLABORATION

Participating RACFs and GPs

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

ACTIVITY MILESTONES AND DURATION

Activity Start Date:	3/05/2022
Activity End Date:	30/06/2027

MILESTONES

Activity Work Plan	Due:	28/05/25, 30/04/26, 30/04/27
Annual Needs Assessment	Due:	15/11/25, 15/11/26
12-month Performance Report	Due:	30/09/25, 30/09/26, 30/09/27
Final Performance Report	Due:	30/09/27

SERVICE DELIVERY DURATION

Service Delivery Date:	1/04/2022
Service Delivery End Date:	30/06/2027

COMMISSIONING APPROACH

Select the commissioning approach:

Other Approach

The PHN has engaged appropriately qualified staff to deliver this activity, and to achieve the planned outcomes.

ACTIVITY PLANNED EXPENDITURE

	FY 24-25	FY 25-26	FY 26-27	FY 27-28
Service Delivery	$311,176.76	$132,793.67	$135,052.17	$311,176.76
Total	**$311,176.76**	**$132,793.67**	**$135,052.17**	**$311,176.76**

AC-EI 3000 - COMMISSIONING EARLY INTERVENTION INITIATIVES TO SUPPORT HEALTHY AGEING AND ONGOING MANAGEMENT.

ACTIVITY DETAILS

Activity Reference:	AC-EI
Activity Number:	3000
Status:	Existing
PHN Program Key Priority Area:	Aged Care

ACTIVITY AIM & OBJECTIVES

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

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

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

PNPHN Early Intervention activities focus on commissioning services to improve access to multi-disciplinary team-based care to older people with or at risk of chronic disease. The aim is to:

- Prevent, identify, and reduce chronic disease and health issues.
- Avoid inappropriate hospital admissions.
- Support healthy ageing in place.
- Improve health outcomes for the elderly.

The activities also build primary health care workforce (in targeted general practices) capability in the care of older people with or at risk of chronic disease and promote self-management and health literacy in older people with or at risk of chronic disease.

DESCRIPTION OF ACTIVITY

Background

In 2024/25, following Needs Assessment review, engagement with key stakeholders and consideration of policy direction and options:

- Pharmaceutical Services Australia (PSA) was engaged to provide Older People's Non-Dispensing Pharmacists into targeted general practices. The contract was executed in late 2023. Participating practices have been identified through an expression of interest (EOI) process.

- South Metropolitan Health Service was engaged to allow primary care referrals to the Metropolitan Community Physiotherapy Service.

With the extension of funding for the Early Intervention activity to 30 June 2027, the PSA engagement to provide Non-Dispensing Pharmacists into targeted general practices will continue to 30 June 2027.

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.

Roles and responsibilities

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

A small team, consisting of activity leads and contract officer lead the Early Intervention activities across the three WA PHNs. Place-based integration managers, and training and practice support staff assist the team. A program logic guides activities.

Target cohort

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

Key activities

The commissioned service providers:

- Support collaborative approaches between multidisciplinary teams and primary care providers as an integral part of person-centered service delivery to:
    - prevent, identify and reduce chronic disease and health issues.
    - support healthy ageing in place
    - avoid ED presentations and hospital admissions.
    - improve health outcomes for older people.
- Recruit, support, and manage allied health staff to deliver services in participating general practices as contractually required or accept referrals from general practices.
- Promote the service to the target general practices.
- Collect and manage the required data as agreed through contract negotiation.
- Provide reports as specified in the contract to allow contract and performance management.
- Ensure the delivery of culturally appropriate care.

The commissioned service provider clinician:

- Builds relationships between the general practice and other relevant services.
- Builds capability of general practitioners and practice staff
- Provides relevant interventions, including education to older people that access the service.
- Provides relevant education to the older people's family members or carers, as necessary, to meet the older person's health needs.

- Increases awareness of local primary health providers regarding needs of local older people and the local services available.
- Provides relevant information/education to the primary health care providers from the participating practices as needed.
- Promotes the uptake of digital health tools including My Health Record.
- Increases awareness of social initiatives and wrap around services that can support older adults to live at home.
- Implements the collection of Quality-of Life measures as agreed between the contractor and WAPHA.

PNPHN will focus on:

Program management

- Financial management including management of unspent funds.
- Commissioning additional services that meet the funding guidance where there are available funds.
- Strengthening evaluation measures.
- Completing and submitting Early Intervention initiative reports as per the agreement variation.

Contract management

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

Participating general practices

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

Integration

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

Communication and engagement

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

PHN NEEDS ASSESSMENT PRIORITIES

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

POPULATION & COVERAGE

TARGET POPULATION:

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

INDIGENOUS SPECIFIC

Will this activity target Aboriginal population? No

ACTIVITY CONSULTATION & COLLABORATION

CONSULTATION

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

- General practitioners
- WA Department of Health
- North Metropolitan Health Service
- South Metropolitan Health Service
- Commissioned Service Providers
- Pharmaceutical Services Australia
- Ageing Australia
- Local government representatives where appropriate
- Representatives from existing aged care service providers.
- Consumer representatives
- Department of Health, Disability and Ageing's Local Network team

COLLABORATION

The PHN will continue to build on established relationships with the WA Department of Health, Health Service Providers, and local government authorities to ensure that the services funded through this activity complement existing support services available through the state and local government, and to facilitate the establishment of appropriate information sharing to support reporting on the effectiveness and impact of this activity.

General practice will be invited to participate in this activity.

ACTIVITY MILESTONES AND DURATION

Activity Start Date:	5/01/2022
Activity End Date:	30/06/2027

MILESTONES

Activity Work Plan	Due:	28/05/25, 30/04/26, 30/04/27
Annual Needs Assessment	Due:	15/11/25, 15/11/26
12-month Performance Report	Due:	30/09/25, 30/09/26, 30/09/27
Final Performance Report	Due:	30/09/27

SERVICE DELIVERY DURATION

Service Delivery Date: 5/01/2022

Service Delivery End Date: 30/06/2027

COMMISSIONING APPROACH

Select the commissioning approach:

Continuing Service Provider

Expression of Interest for general practices

ACTIVITY PLANNED EXPENDITURE

	FY 24-25	FY 25-26	FY 26-27	FY 27-28
Service Delivery	$478,387.10	$494,391.80	$503,057.97	$0.00
Operational	$61,165.31	$36,782.89	$37,150.72	$0.00
Total	**$539,552.41**	**$531,174.69**	**$540,208.69**	**$0.00**

AC-CF 4000 – CARE FINDER PROGRAM

ACTIVITY DETAILS

Activity Reference:	AC-CF
Activity Number:	4000
Status:	Existing
PHN Program Key Priority Area:	Aged Care

ACTIVITY AIM & OBJECTIVES

In response to the Royal Commission into Aged care Safety and Quality, the Australian Government has funded Primary Health Networks (PHNs) to undertake dedicated activities which support better health, wellbeing and access to primary care and aged care services for senior Australians. The overarching goal of these activities is to delay entry into Residential Aged Care Facilities (RACFs) and reduce avoidable hospitalisations for older people.
The care finder program aims to provide specialist and intensive assistance to help people within the care finder target population to understand and access aged care and connect with other relevant supports in the community.
To this end, WA Primary Health Alliance (WAPHA) will:

- Maintain the network of commissioned care finders in the Perth North PHN (PNPHN) region.
- Support and promote continuous improvement of the care finder program via a community of practice.
- Facilitate improved integration of care finder into local health, aged care, and other community systems in the PHN region.
- Manage care finder funds including use of unspent funds for targeted care finder activities, such as care finder related training, quality improvement activities to improve reporting, and increasing assertive outreach and local integration.

The care finder program aims to improve health outcomes for people in the care finder target population by facilitating equitable access and allocating efficiency to services for older adults. This will include:

- Improved coordination of support when seeking to access aged care.
- Improved understanding of aged care services and how to access them.
- Improved openness to engage with the aged care system.
- Increased care finder workforce capability to meet client needs.
- Increased rates of access to aged care services and connections with other relevant supports.
- Increased rates of staying connected to the services they need post service commencement.

DESCRIPTION OF ACTIVITY

Background

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

In 2022, there were nearly 180,000 people aged 65 years and over living in the PHN region, representing about 17% of its population, similar to the state rate. While it is difficult to accurately measure the size of the PHN's target care finder population, data analysis indicates that the largest groups include people from non-English speaking backgrounds and people who require assistance with cognitive and emotional tasks. However, other groups also require support such as care leavers, people with previous experiences with trauma, and older people who identify as Aboriginal or LGBTIQ+.

Service establishment

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

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

PNPHN commissioned care finder services to:

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

Service provision between 1 July 2025 and 30 June 2029

The extension of care finder funding to 30 June 2029 allows WAPHA to extend current contracts to 30 June 2026, while service planning occurs for WAPHA to review existing services and implement strategies to strengthen care finder coverage across PNPHN.

- Planning for the use of non-recurrent funds has been undertaken, and a request has been made to roll over funds to future years. WAPHA intends to use the rolled over funds to:
    - Contribute to client centered service transition processes, where transition is required.
    - Expand assertive outreach, to ensure the ongoing development of relationships and networks.
- Strengthen communities of practice and program improvement activities in the PHN, with a focus on addressing variation between provider performance and reporting, expanding knowledge of aged care reforms, and increasing patient reported outcome measures.

Roles and responsibilities

WAPHA's Commissioned Services Portfolio, which works across the three WA Primary Health Networks (PHNs), is responsible for the delivery of the care finder initiative. A dedicated care finder Activity Lead (using operational funds from each PHN) has been employed to coordinate WAPHA's care finder activities and to facilitate WAPHA facilitated care finder network community of practice.

An executive sub-committee oversees all PNPHN aged care activity including care finders to ensure it aligns with funding requirements, guidance, and WAPHA's Strategic Plan 2023-2026.

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

Key activities

PNPHN will:

Program management

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

Contract management

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

Program improvement

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

Integration

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

PHN NEEDS ASSESSMENT PRIORITIES

- Improve access to primary care services, early intervention, cultural safety and health literacy for multicultural communities through a care navigation service (Metro)
- Enable access to care finder services for older people (Metro)

- Support people living with dementia and their carers to navigate the aged care system and access appropriate services (Metro)

POPULATION & COVERAGE

TARGET POPULATION:

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

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

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

INDIGENOUS SPECIFIC

Will this activity target Aboriginal population? No

ACTIVITY CONSULTATION & COLLABORATION

CONSULTATION

The PHN engaged the following organisations and groups to support the establishment of care finders

- Department of Health, Disability and Ageing Local Network Team
- North Metro Health Service
- East Metro Health Service
- District Leadership Groups
- Aged Care Interagency Groups
- Local Government Authorities
- Council of the Ageing WA
- Ageing Australia National Aboriginal Community Controlled Health Organisation (NACCHO)
- Aboriginal Health Council of WA (AHCWA)
- Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Community Controlled Organisations (ACCOs) as relevant.

COLLABORATION

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

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

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

- WA Department of Health
- Health Service Providers
- Local Government Authorities
- Sector peak bodies and service providers

ACTIVITY MILESTONES AND DURATION

Activity Start Date: 1/01/2022

Activity End Date: 30/06/2029

MILESTONES

Activity Work Plan	Due:	28/05/25, 30/04/26, 30/04/27, 30/04/28, 30/04/29
Annual Needs Assessment	Due:	15/11/25, 15/11/26, 15/11/27, 15/11/28, 15/11/29
12-month Performance Report	Due:	30/09/25 30/09/26, 30/09/27, 30/09/28, 30/09/29
Final Performance Report	Due:	Due 30/09/29

SERVICE DELIVERY DURATION

Service Delivery Date: 1/01/2023

Service Delivery End Date: 30/06/2029

COMMISSIONING APPROACH

Select the commissioning approach:

Continuing Service Provider

ACTIVITY PLANNED EXPENDITURE

	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29
Service	$2,622,651.01	$2,930,350.59	$2,983,143.31	$3,045,278.64	$3,028,724.46
Operational	$408,002.28	$252,462.50	$252,462.50	$252,462.50	$269,016.68
Transition of the ACH Program	$153,909.69	$0.00	$0.00	$0.00	$0.00
Total	**$3,184,562.98**	**$3,182,813.09**	**$3,235,605.81**	**$3,297,741.14**	**$3,297,741.14**

AC-OSP 5000 - AGED CARE ON-SITE PHARMACIST MEASURE

ACTIVITY DETAILS

Activity Reference:	AC-OSP
Activity Number:	5000
Status:	Existing
PHN Program Key Priority Area:	Aged Care

ACTIVITY AIM & OBJECTIVES

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

The Aged Care On-Site Pharmacist (ACOP) measure provides funding to community pharmacies and residential aged care homes (RACHs) to employ on-site pharmacists to work in RACHs. Pharmacists participating in the measure will regularly review medications to reduce medication related harm and optimise the use of medicines. They will work with aged care staff to improve health outcomes of residents and build confidence with families and carers. The on-site pharmacist in their role will support aged care providers to meet many of the Aged Care Quality Standards, such as through supporting informed decision making around medications and assisting with clinical care.

Under the measure, the Department has funded PHNs to assist RACHs to engage aged care on-site pharmacists to work in a clinical role to improve medication management for residents.

This activity aims to:

- Increase uptake of aged care on-site pharmacists by RACHs around Australia
- Improve access to aged care on-site pharmacists in RACHs

DESCRIPTION OF ACTIVITY

Background

The Aged Care On-Site Pharmacist (ACOP) measure is a direct response to recommendation 38 of the Final Report of the Royal Commission into Aged Care Quality and Safety, which stated that aged care providers should actively seek to engage allied health practitioners, including pharmacists, by no later than 1 July 2024.

The Aged Care On-Site Pharmacist measure is intended to improve medication management and safety for residents through aged care credentialed pharmacists working on-site in RACHs in a clinical role.

Rationale

Polypharmacy is common in older people because they are more likely to be living with several chronic conditions, requiring medicines to prevent or control symptoms. About 80% of Australia's population aged 65 years and over have one or more chronic conditions, and over half (51%) have two or more. Because people become more sensitive to the effects of medicines as they age, the consequences of polypharmacy tend to be more serious in older people.

Polypharmacy is also associated with harms including delirium and falls, hospitalisation, reduced quality of life and premature morbidity and mortality.

Roles and Responsibilities

WA Primary Health Alliance's (WAPHA's) Primary Care Portfolio, which works across the three WA PHNs, is responsible for the delivery of the Aged Care On-Site Pharmacist measure. An executive sub-committee oversees all PHN aged care activity including the ACOP measure to ensure it aligns with funding requirements and guidance, and WAPHA's Strategic Plan 2023-2026.

Target cohort

RACH's in WA, including those already participating in ACOP, to support understanding of the ACOP role, their entitlements and ongoing participation requirements.

Pharmacists in WA, to support understanding of the opportunity, eligibility requirements and employment opportunities in RACH's.

Key Activities

The Aged Care On-Site Pharmacist measure provides funds for Perth North PHN (PNPHN) to:

- Identify eligible pharmacists seeking to participate in the ACOP measure
- Coordinate the provision of information to RACHs in the PSPHN region about the ACOP measure, including information about eligible pharmacists seeking to be employed by RACH's under the measure.
- Assist RACHs, including those already participating in the ACOP Measure with their understanding of the Measure and avenues for further assistance.
- Manage requests for support from RACHs seeking to engage eligible pharmacists
- Support participating RACHs to engage eligible pharmacists to work on-site
- Support communication and collaboration between RACHs, their pharmacist, their residents' GPs and other health professionals
- Support communication and collaboration between pharmacists employed by RACHs under this measure within the PSPHN region.

Priority activities for 2025:

- Recruitment of dedicated resource to coordinate and manage the ACOP activity across the three WA PHNs
- Promotion of the ACOP activity, eligibility requirements and career opportunity to pharmacists in WA.
- Consulting with the providers of the required accredited training programs pharmacists are required to complete to be eligible to participate in ACOP (Australian Pharmacy Council (APC), Pharmaceutical Society of Australia, University of WA) to understand availability, cost, time requirements and modality
- Establishment of a database of credentialled pharmacists who are seeking to take up this opportunity
- Communication and promotion of the ACOP measure to Residential Aged Care Homes via established communication pathways, promoting the value proposition to the RACH team, residents and visiting clinicians.
- Establish and promote clear communication pathways to enable RACHs and pharmacists to engage with WAPHA, and each other as appropriate.

PHN NEEDS ASSESSMENT PRIORITIES

- Enable access to local aged care services, including residential and at-home care.
- Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible.

POPULATION & COVERAGE

TARGET POPULATION:

Residents of Perth North PHN who are living in Residential Aged Care Homes, particularly those with complex and chronic conditions and who are currently prescribed 5+ medications.

INDIGENOUS SPECIFIC

Will this activity target Aboriginal population? Yes

ACTIVITY CONSULTATION & COLLABORATION

CONSULTATION

- Regional Aged Care collaboratives
- Primary care portfolio including digital health team
- RACHs
- Pharmacists
- General Practice

COLLABORATION

- Pharmacy peak bodies (WA)
- Pharmacist education and training providers
- RACHs
- Ageing Australia (WA)
- Residential aged care forums

ACTIVITY MILESTONES AND DURATION

Activity Start Date:	24/06/2025
Activity End Date:	30/09/2027

MILESTONES

Activity Work Plan	Due:	28/05/25, 30/04/26, 30/04/27
Annual Needs Assessment	Due:	15/11/25, 15/11/26
12-month Performance Report	Due:	30/09/25, 30/09/26, 30/09/27
Final Performance Report	Due:	30/09/27

SERVICE DELIVERY DURATION

Service Delivery Date:	1/07/2025
Service Delivery End Date:	30/06/2027

COMMISSIONING APPROACH

Select the commissioning approach:

Other Approach

ACTIVITY PLANNED EXPENDITURE

	FY 24-25	FY 25-26	FY 26-27	FY 27-28
Service Delivery	$120,000	$130,000	$130,000	$0.00
Total	**$120,000**	**$130,000**	**$130,000**	**$0.00**