Perth South PHN Activity Work Plan

Community Health & Hospitals Program

Summary View
2022/2023 – 2025/26

Presented to the Australian Government Department of Health and Aged Care

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CHHP 2000 – headspace Demand Management and Enhancement Program

Funding Schedule

Primary Mental Health Care

Activity Title

headspace Demand Management & Enhancement Program

Activity Number

2000

Activity Status

Modified

PHN Program Key Priority Area

Mental Health Priority Area 2: Child and youth mental health services

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Aim of Activity

To increase the efficiency and effectiveness of primary mental health services for young people aged 12 to 25 with, or at risk of, mental illness by:

- Improving data collection and reporting on headspace wait times.
- Improving access to and integration of primary mental health care services, to ensure young people with mental illness receive the right care in the right place at the right time by reducing wait times for clinical services at designated headspace centres for young people with the highest need.

Description of Activity

This activity is part of the headspace Wait Time Reduction Program which:

- Identifies existing headspace services experiencing high wait times for clinical services and develops and implements activities and initiatives to assist in reducing these wait times.
- Supports the long-term sustainability of the headspace program by improving access to services, appropriately managing demand, and improving the health outcomes of young people aged 12 to 25 with, or at risk of, mental illness, and their families.
- Increases access to clinical support through a dedicated online support service for young people in areas experiencing increased demand (provided by headspace National).
- Improves data collection and reporting on headspace wait times to support

planning, research, and analysis of headspace service demand.

The following activities will occur:

i. headspace Mandurah
   - Recruit a Community Engagement Officer to promote and support the brief intervention program.
   - Recruit a Program Lead to be trained in intervention and coordinate its delivery within the centre.
   - Provide a stipend for a PHD student to undertake evaluation of the intervention program.

ii. headspace Rockingham
   - Recruit a Community Engagement Officer to promote and support the brief intervention program.
   - Recruit a Program Lead to be trained in intervention and coordinate its delivery within the centre.
   - Provide a stipend for a PHD student to undertake evaluation of the intervention program.

Perth South PHN Needs Assessment

Priorities	**Page reference**
Ensure integrated and stepped care services are available for people experiencing mental health issues, including younger people	18
Increase access to low cost- local mental health services in outer-suburbs and areas with limited-service availability but high demand.	18
Improve access to early intervention suicide prevention services	18

Target Population Cohort

This activity is targeted to individuals:

- Young people aged 12 –25

Coverage

Local government areas of Mandurah and Rockingham within Perth South PHN

Activity Duration

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

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
CHHP – headspace Wait Time Reduction Program	$331,500.00	$293,500.00	$287,000.00

CHHP 3000 – Choices Expansion

Funding Schedule

Primary Mental Health Care

Activity Title

Choices Expansion

Activity Number

3000

Activity Status

Modified

PHN Program Key Priority Area

Mental Health Priority Area 7: Stepped care approach

Aim of Activity

To improve the health and wellbeing of people at risk of poor health outcomes and difficulty accessing appropriate services who have frequent contact with hospital emergency departments by linking these individuals, who would previously be discharged to their own recognisance, with place-based community service providers. A key aspect of the service is the utilisation of peer workers and connecting service users to general practice.

The Choices mental health program is for people with moderate and, in some cases, severe mental illness and is targeted at those who lack the resources (material and non-material) to manage "acute" personal difficulties and, as a result, enter the healthcare system as "crisis" or "social care" presentations, characterised by:

- insufficient informal personal supports to manage crises
- mild, moderate and, in some cases, severe mental illness
- significant associated functional impairment (days out of role)
- Alcohol and other Drug comorbidity/intoxication
- are unable to equitably access MBS (Medicare Benefit Schedule) treatments due to a constellation of overlapping factors, including:
    - job insecurity
    - material disadvantage
    - social isolation
    - poor health literacy
    - other social, economic, cultural, and personal reasons

- poorly developed self-regulation and problem-solving skills

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Description of Activity

Choices is a non-clinical service designed to in-reach into the emergency departments to assist individuals with poor personal and socials supports who are 'frequent attenders' at metropolitan hospital emergency departments judged to be at-risk to get off the "crisis cycle."

A unique aspect of the service is the use of peer workers to engage with people in settings that may be confronting for them. Peers provide brief interventions and immediate support and can assist clients with personalised support including, engaging with mental health and alcohol and other drug services as well as other supports such as accommodation and financial services, utilising a range of strategies such as low intensity psychological interventions, stress management, shared problem solving, goal setting and motivational interviewing.

The Choices Expansion (funded under a CHHP grant) involved two separate but connected service developments. Firstly, the provision of the Choices service at additional metropolitan hospital emergency departments. Secondly, the commissioning of a single mobile clinical team to provide enhanced clinical support (called "Extra Choices") for Choices clients with higher acuity and co-occurring mental health and alcohol and drug use within emergency departments where Choices operates.

The Perth North and South PHNs commissioned the additional non-clinical emergency department in-reach service provision, and the WA Mental Health Commission were responsible for commissioning the mobile team (as per the conjoint submission requirements of the CHHP grants).

Since these services were established the environment in which Choices Expansion operates has continued to evolve. As originally planned clients are drawn from a clinical population characterised by co-occurring alcohol and other drug and mental disorders set against a background of generalised instrumental, psychosocial, and personal dysfunction ("comorbidity-plus"). They include a significant proportion of Aboriginal and Torres Strait Islander people (~30% of the Choices cohort). However, the proportion of referrals who are at risk of harm to self – suicide, suicide attempts, and self-neglect - has increased steadily. The future development of the Choices service will need to be set against the new operational context which includes the conjoint development of targeted community-based suicide prevention and aftercare services, including embedded peer-supports and other opportunities that may arise from the National Mental Health and Suicide Prevention Agreement and the WA

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

Perth South PHN Needs Assessment

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

Target population Cohort

Individuals with poor personal and socials supports who are 'frequent attenders' at metropolitan hospital emergency departments judged to be at-risk to get off the 'crisis' cycle.

Coverage

Local government areas of Armadale, Mandurah, Rockingham, and Serpentine-Jarrahdale within Perth South PHN.

Activity Duration

Activity Start Date	Activity End Date
1 January 2020	30 June 2024

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
CHHP - Expansion of Choices Service	$1,291,348.00	$491,348.00	$0.00

CHHP 4000 – MultiCare for Chronic Heart Failure

Funding Schedule

Core Funding

Activity Title

Multi Care for Chronic Heart Failure

Activity Number

4000

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

To develop and implement models of multidisciplinary care for chronic heart failure patients across the Perth South PHN and Country WA PHN regions as informed by the WA Primary Health Alliance Needs Assessment.

This activity will support general practice in leading and coordinating the provision of multidisciplinary care, with appropriate specialist support, consistent with recommendations from the National Heart Foundation of Australia.

Description of Activity

This activity will:

- Develop resources and support general practice in identifying and referring patients to services; coordinating multidisciplinary teams; collaborating with pharmacists; and developing the role of practice nurses in chronic heart failure care management.
- Establish Project Governance with representation from WAPHA, general practice, community pharmacy, acute care providers, the Hearth Foundation of Australia, and people with lived experience (patients and carers).
- Select two locations to trial multidisciplinary primary care for patients with chronic heart failure, reflecting Needs Assessment priorities of the local service area and service capacity.
- Develop an implementation plan for the selected trial sites, and evaluation

framework–consistent with the Quintuple Aim–to inform the development of recommendations.

- Pilot a general practice led, patient centred multidisciplinary model of care in the Perth South PHN region, which focuses on:
    a) Building capacity in general practice.
    b) Using quality improvement cycles to optimise general practice processes.
    c) Empowering and educating chronic heart failure patients and their carers.
    d) Developing the role of practice nurses in CHF management.
    e) Collaborating with pharmacists.
    f) Strengthening connection and collaboration between primary and tertiary care.
- Assess the capacity of the primary care workforce to manage chronic heart failure through primary care-led multidisciplinary care and make recommendations for developing the primary care workforce as appropriate.

This activity is also delivered in Country WA PHN and funded through the Perth South PHN budget.

Perth South PHN Needs Assessment

Priorities	**Page reference**
Reduce non-urgent emergency department attendances and improve access to alternative services.	12
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management	11
Increase access to best-practice management for people with chronic heart failure.	11
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home.	41
Support primary health care providers to provide culturally appropriate chronic disease management for Aboriginal populations and build capacity for patient self-management.	34

Target population Cohort

Secondary patients

Coverage

Perth South PHN

Consultation

Develop relationships with key stakeholders including peaks and provider organisations to improve coordination, integration, and continuity of care at the tertiary and primary care interface.
Consultation is ongoing with key stakeholders, in the form of an Expert Reference Group, an internal Steering Committee, and ad hoc consultation. Stakeholders include:

- General practitioners and GP Hospital Liaisons
- Geriatrician
- Medical Officers
- Health Service Providers: East Metropolitan Health Service, WA Country Health Service
- Chronic heart failure academics
- National Heart Foundation of Australia
- Royal Australian College of General Practitioners
- Allied health professionals: exercise physiologists, physiotherapists, practice nurses, registered nurses, clinical nurse specialists, pharmacists, nurse practitioners
- Multi-disciplinary working group
- Benchmarque Group
- Aboriginal health service providers
- Australian Practice Nurse Association
- Pharmaceutical Society of Australia
- Health Consumers Council

Activity Duration

Activity Start Date	Activity End Date
1 July 2022	31 December 2025

Activity Start Date	Activity End Date
1 July 2022	31 December 2025

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25

CHHP - Multi Care for Chronic Heart Failure	$729,600.00	$1,368,000.00	$1,368,000.00

END