



Country WA PHN Activity Work Plan

Community Health & Hospitals Program

Summary View
2022/2023 – 2025/2026

**Presented to the Australian Government Department of Health
and Aged Care**

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CHHP 2000 – headspace Wait Time Reduction Program

Funding Schedule

Primary Mental Health Care

Activity Title

headspace Wait Time Reduction program (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

Aim of Activity

The aim of this Capital works Agreement for headspace Centre Expansion is to enhance the quality of experience for young people aged 12 to 25 years in accessing mental health services provided through headspace Albany.

Description of Activity

Capital works funds will enable the use for the Albany headspace Centre to fit out the neighbouring premises with additional counselling rooms, flexible meeting and group spaces, and an expanded working area.

The additional space will enable improved access to mental health services for youth in the Great Southern.

Country WA PHN Needs Assessment

Priorities

Page reference

Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Goldfields, Midwest, Wheatbelt, South West).	15
Improve access to mental health services in the Great Southern.	29

Activity Duration

Activity Start Date

1 July 2021

Activity End Date

30 June 2025

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
CHHP – headspace Wait Time Reduction Program	\$655,410.96	\$892,467.00	\$892.467.00

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 Heart 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.

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
- Benchmark Group
- Aboriginal health service providers
- Australian Practice Nurse Association
- Pharmaceutical Society of Australia
- Health Consumers Council

Activity Duration

Activity Start Date

1 July 2022

Activity End Date

31 December 2025

Service Delivery Start Date

1 July 2022

Service Delivery End Date

31 December 2025

Activity Planned Expenditure

Funding Stream	FY 22 23	FY 23 24	FY 24 25
CHHP - Multi Care for Chronic Heart Failure	This activity is funded through the Perth South PHN budget		

END
