WA Primary Health Alliance PHN PHN Pilots & Targeted Programs Country WA 2024/25 - 2027/28 Activity Summary View

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

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Contents

PP & TP GCPC 1000 - Greater Choice for At Home Palliative Care Project

Activity Metadata

Applicable Schedule

PHN Pilots and Targeted Programs - Country WA

Activity Prefix

PP&TP-GCPC

Activity Number

1000

Activity Title

PP & TP GCPC 1000 - Greater Choice for At Home Palliative Care Project

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Aged Care

Aim of Activity

The continuation of the Greater Choices for At Home Palliative Care (GCfAHPC) will run nationally over four years from 2025-2029. The purpose of the grant is to improve and increase access to quality palliative care at home, in the community. The aim is to support people who choose to remain at home to receive palliative care and end-of-life care. The objectives of the Program and this grant opportunity are to:
• improve awareness (workforce and community) and access to safe, quality palliative care at home and support end-of-life care systems and services in primary health care and community care
• enable the right care, at the right time and in the right place to reduce unnecessary hospitalisations
• generate and use data to support continuous improvement of services across sectors, and
• use available technologies to support flexible and responsive palliative care at home, including in the after-hours period.

The intended outcomes of the Program and this grant opportunity are to:
• improve the capacity and responsiveness of services to meet local needs and priorities
• improve patient access to quality palliative care services available in the home and improved capacity of carers to support people at home, and
• improve coordination of care for patients, across health care providers and integration of palliative care services in their (PHN) region.

The GCfAHPC grant will be utilised to build on work undertaken in FY 23/24 and FY 24/25. Our focus for FY 25/26 will include:

• Promotion of choice at end –of-life by building community awareness about Advance Care Planning (ACP) through consolidation of activities commenced in FY 24/25 which engaged two peak bodies – Palliative Care WA and LinkWest.
• Improve access to ACP as part of routine health assessments namely the 75+ and Indigenous Health Assessments (IHA) in general practice.
• Build capacity and capability in general practice to identify patients who may be in their last 12 months of life and who have a high risk of unplanned hospitalisation (improved utilisation of Primary Sense Complexity Report (Report 5).
• Develop screening processes for general practice to identify patients who may be in the last 12 months of life but who do not meet the criteria for referral to Specialist Palliative Care community services.
• Implement a Supportive Care model of care in general practice to proactively manage the expected deterioration of patients with an ACG score of 5 with the intention of reducing avoidable ED presentations.

In addition, CWAPHN staff will work with key Palliative Care and EOL stakeholders at a state, PHN, and health region level to promote primary care provided palliative care services in the WA palliative care and EOL system.

These activities will be undertaken:
• with a particular focus on people at risk of poor health outcomes and people with advanced chronic disease.
• in the Goldfields – Esperance and Mid-West health region with the intention to develop resources and programs that can be implemented across the PHN.

Description of Activity

Background

CWA PHN comprises of seven unique regions. The continuation of the GCfAHPC funding will support WAPHA to build on activities undertaken in the town of Kalgoorlie (Goldfields region) and extend this work to the Esperance area (Goldfields) and Geraldton (Mid-West region).

Goldfields Region Overview:

The Goldfields-Esperance region spans 771,276 square kilometres and consists of two ABS Statistical Area Level Three (SA3) sub-regions: the Goldfields SA3 and Esperance SA3.
The Goldfields-Esperance region includes a diverse Aboriginal community with many distinct language groups and remote communities.
The Goldfields SA3 has a concerning level of chronic disease among its residents, and the highest or second highest rate in the Country WA PHN for six of the ten chronic conditions.
There is a lower utilisation of Chronic Disease Management Plans (CDMPs) in the Goldfields and Esperance at 11% and 6% compared with the state rate (14%)
Coronary Heart Disease, COPD, and Lung Cancer are the most common causes of death, and the rates are above those for the whole of WA.

Mid West Overview:

The Mid West region of WA services a population of approximately 68,000 people and is located in the northern central area of WA. It covers more than 605,000 square kilometres, approximately one quarter of the state's total land mass. It encompasses two ABS Statistical Area Level Three (SA3) sub regions: the Mid West SA3, and the Gascoyne SA3.
The Mid West region includes a diverse Aboriginal community with many distinct language groups and remote communities.
Chronic disease is a significant issue in the Mid West region. It contributes substantially to the burden of disease, and there are high rates of avoidable deaths due to chronic conditions.
The Gascoyne SA3 has the highest rate of people born overseas with low English proficiency in the Country WA region.
The Mid West region has a large and growing older adult population. By 2030, nearly one quarter of the Mid West SA3 on one fifth of the Gascoyne SA3 residents will be aged over 65.

Coronary heart disease, COPD and dementia are among the leading causes of disease burden for people aged 65 and over.
There are no at-home palliative care providers in the Mid West region, with many older people dying in hospitals or aged care services.
The Mid West has a relatively large Aboriginal population compared to state rates.

Rationale
WA Country Health Service (WACHS) provides Country WA Specialist Palliative Care services. Fundamental to the model of care is the delivery of palliative care by generalist primary care staff, where the patient lives. The WACHS place-based nurse-led service provides advice and consultancy to primary care generalists and community-based patient care. The medical governance remains with the General Practitioner (GP) or alternatively a shared model of care is provided by the Palliative Care Physician and GP.

The generalist nature of country primary care providers, competing demands and challenges of working in rural and remote locations can be a barrier to palliative care in the home. There is a need to:
• increase awareness of advanced care planning (ACP) and the benefits of palliative care with community and primary care workforce.
• assist primary care workforce to identify palliative care need within their patient cohort and develop a plan of care that reflects the generalist palliative care role.

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

A team, consisting of an activity lead, project officer and quality improvement coach lead GCfAHPC activities across the three WA PHNs. Each WA PHN contributes to the cost of the team via the available GCfAHPC expansion funds. Activities are costed to the relevant PHN. Project management, place-based integration managers, and practice support staff assist the team. A program logic guides activities.

Key activities
The PHNs Needs Assessment has been updated to include a section on Palliative Care, this information guides the PHNs Greater Choice activities.

• Activity 1: improve community awareness of Advance Care Planning to promote informed choice and future (end of life) planning by consolidating activities delivered through LinkWest and PCWA to build capacity and capability in Community Resource Centres (CRC's) in CWAPHN.
• This will include:
• Roll-out of ACP foundation training to all CRC's by PCWA.
• A range of community awareness events coordinated by each CRC to enhance understanding of ACP in community.
• ACP information to be promoted by LinkWest on their webpage.
• A small grant will be provided to LinkWest to coordinate this work.

• Activity 2: Centres improving access to ACP through routine health assessments including IHA's in general practice. This includes:
• Enhancing ACP capacity and capability of the QI Coaches at WAPHA who support general practice in CWAPHN to facilitate the implementation of a systematic approach to the inclusion of ACP in these assessments.
This initiative encourages early end-of life planning in an at-risk cohort and will facilitate ACP for patients who are more likely to be diagnosed/have a diagnosis of dementia.
• O.33 FTE will be funded within the QI Coach to support this increase in scope.
• Introduction of the Australian Modified Karnofsky Performance Scale (Karnofsky Scale) in general practice to support screening for eligibility for the "End of Life Pathway" as per the Support at Home legislation.

• Activity 3: focuses on building capacity and capability related to the generalist approach to palliative care in a small number of general practices. This includes:
Provision of a small grant ($20k per practice) to two general practices to consolidate the work relating to the Palliative Care Champions project completed in FY24/25. This grant will build on the introduction of ACP in routine health assessments and Chronic Disease management plans as well as progress the implementation of a new model which WAPHA has developed called “Supportive Care”.

• Activity 4: concentrates on primary care palliative and EOL care continuous quality improvement (QI) and includes:
o the refinement of QI activities specific to ACP and the generalist approach to palliative care.
o assisting practices with audits (After Death Audits).
o activities to improve ACP awareness.
o Utilisation of Primary Sense data (Report 5) to identify patients at high risk of hospitalisation and potentially unmet palliative care needs.
o This work is supported by a dedicated QI Coach (0.33 FTE)

The GCfAHPC team participate in the national GCfAHPC evaluation and in a range of forums to promote primary care provided palliative care services in the WA palliative care and EOL system and inform service and system improvement.

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 local aged care services, including residential and at-home (Mid West).	73
Enable access to local aged care services, including residential and at-home (Wheatbelt).	142
Enable access to local aged care services, including residential and at-home (Kimberley).	53

Activity Demographics

Target Population Cohort

Primary care workforce, particularly GPs, practice staff and ACCHS staff in their role as “generalist” palliative care providers.
General practice clients living with (advanced) chronic disease whose needs may be better met by a palliative approach to care.
Community members to increase ACP awareness.

Indigenous Specific

Yes

Indigenous Specific Comments

This activity focus includes Aboriginal and Torres Islander populations through the promotion of ACP in IHA's and the inclusion of culturally appropriate materials to support ACP awareness.
WAPHA will continue to work with our existing partner, the Aboriginal Health Council of WA (AHCWA) to promote awareness of ACP and access to palliative care. We are also interested in developing a relationship with the newly formed National Aboriginal and Torres Strait Islander Palliative Care Association (NATSIPCA).

Coverage

Whole Region

No

SA3 Name	SA3 Code
Mid West	51104
Goldfields	51103

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 Greater Choices for At Home palliative Care measure, including:
- WA GP Panel – Special Interest Group: Care of the older person
- Aboriginal organisations/communities
- General practitioners and general practice staff
- WA Country Health Service
- Palliative Care Australia
- Palliative Care Outcomes Collaborative
- Goldfields Health Professionals Network
- WA Health End of Life and Palliative Care Team
- Palliative Care WA
- The Advance Project
- End of Life Directions for Aged Care (ELDAC)
- Silver Chain Specialist Palliative Care Service
- Palliative and Supportive Care Education (PaSCE)
- Royal Australian College of General Practitioners (WA) (RACGP WA)
- Best Practice

Collaboration

Ongoing collaboration with:
- Aboriginal Health Council of WA
- Targeted general practices.
- Aged Care provider representatives
- Palliative Care WA
- Linkwest
- Palliative and Supportive Care Education WA
- Program of Experience in the Palliative Care Approach

WA Country Health Service Palliative Care Team

Activity Milestone Details/Duration

Activity Start Date

28/02/2018

Activity End Date

30/10/2025

Other Relevant Milestones

- Activity Work Plan due 28 May 2025.
- Final 12-month Performance Report due 30 September 2025.
- Financial Acquittal Report due 30 September 2025.

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
Greater Choice for At Home Palliative Care	$532,071.82	$970,075.53	$23,069.04	$0.00	$0.00	$1,525,216.39
Total	**$532,071.82**	**$970,075.53**	**$23,069.04**	**$0.00**	**$0.00**	**$1,525,216.39**

PP&TP-EPP 4000 - PHN Endometriosis and Pelvic Pain GP Clinics

Activity Metadata

Applicable Schedule

PHN Pilots and Targeted Programs - Country WA

Activity Prefix

PP&TP-EPP

Activity Number

4000

Activity Title

PP&TP-EPP 4000 - PHN Endometriosis and Pelvic Pain GP Clinics

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

To support general practice clinics to improve access for patient's diagnostic treatment and referral services for endometriosis and pelvic pain, build the primary care workforce to manage this chronic condition and provide improved access to new information and care pathways.

The Australian Government Department of Health, Disability and Ageing2022-23 Budget committed $16.4m over four years to support the establishment of targeted Endometriosis and Pelvic Pain GP Clinics (GP Clinics) in the primary care setting. The intention of these GP clinics is to maximise the role of the GP led multidisciplinary care team in the management of endometriosis and pelvic pain, and to embed the GP as a core part of the care pathway for this chronic condition, optimising the role of primary care.

Endometriosis can be difficult to diagnose and that delay between the onset of symptoms and diagnosis averages 7 years. These GP clinics will provide more people with access to multi-disciplinary care with a focus on improving diagnostic delay and to promote early access to intervention, care and treatment.

Description of Activity

The Australian Government Department of Health, Disability and Ageing announced Pioneer Health Albany as the Endometriosis and Pelvic Pain Clinic within the Country WA PHN.
The Primary Health Network (PHN) supports Pioneer Health Albany to utilise funding to provide enhanced services for the treatment and management of endometriosis and pelvic pain, based on the needs of the community, including but not limited to:
• recruitment of specialised staff, including nurse practitioners and allied health professionals.

• capital costs such as fit-out costs for pelvic physiotherapy areas and associated equipment.
• resources, training and development.

GP Clinics are not intended to duplicate resources of investment already available to the community, instead they are expected to:
• improve access for patients to diagnostic, treatment and referral services for endometriosis and pelvic pain
• provision of access to new information, support resources, care pathways and networks
• provision of an appropriately trained workforce with expertise in endometriosis and pelvic pain
• directly benefiting patients from rural and regional areas
• providing enhanced support to priority populations
• increase access to support services, either through a nurse navigator or referral pathway.

The PHN will support data collection for program monitoring and continuous evaluation. GP clinics are required to submit six monthly reports with data items proposed by Australian Government Department of Health, Disability and Ageing.

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 (Goldfields-Esperance).	5
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 (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

Women with endometriosis and pelvic pain

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The PHN will work with the Pioneer Health Albany

Collaboration

The PHN will collaborate with Pioneer Health Albany and other stakeholders as they are identified

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Activity Milestone Details/Duration

Activity Start Date

28/02/2023

Activity End Date

30/12/2026

Service Delivery Start Date

23/03/2023

Service Delivery End Date

30/06/2026

Other Relevant Milestones

Twelve Month reports Performance Reports	30/09/25, 30/09/26
Activity Work Plan	28/05/25
Financial Acquittal Reports	30/09/25 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: 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
Endometriosis and Pelvic Pain GP Clinics	$180,000.00	$180,000.00	$180,000.00	$0.00	$0.00	$540,000.00
Endometriosis and Pelvic Pain GP Clinics - Operational	$16,764.00	$16,764.00	$11,764.00	$0.00	$0.00	$45,292.00
Total	**$196,764.00**	**$196,764.00**	**$191,764.00**	**$0.00**	**$0.00**	**$585,292.00**