WA Primary Health Alliance
Better health, together

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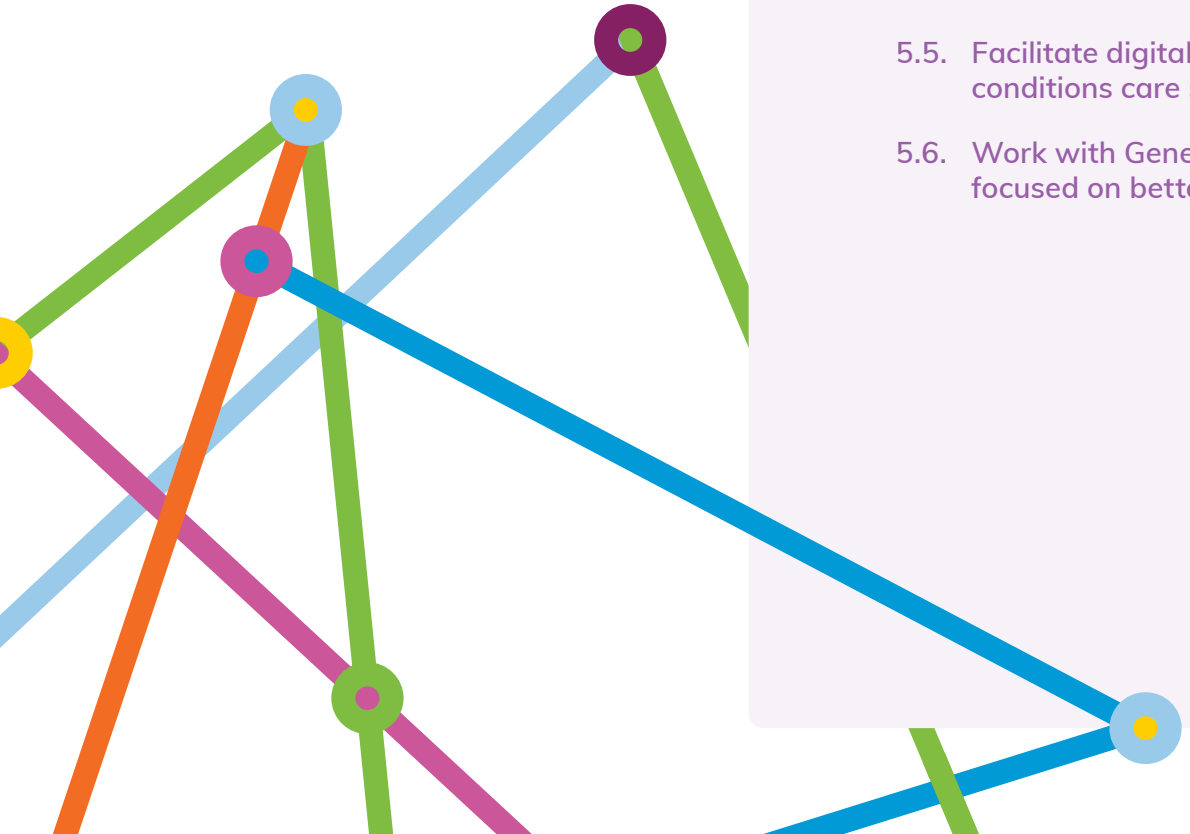
PERTH NORTH, PERTH SOUTH, COUNTRY WA
An Australian Government Initiative

Chronic Conditions Care Strategy

2025-2027

Contents



WAPHA Chronic Conditions Care Strategy

1. About the WA Primary Health Alliance Chronic Conditions Care Strategy

The WA Primary Health Alliance (WAPHA) Chronic Conditions Care Strategy has been developed to complement the Strategic Plan 2023-2026. The Strategy provides an overview of WAPHA's priorities and strategic directions for chronic conditions care and the principles that underpin WAPHA's approaches.

The Chronic Conditions Care Strategy aligns with WAPHA's vision of Better Health Together and mission:

To shape, strengthen and sustain primary health care in Western Australia through partnerships and strategies that demonstrate a one health system philosophy and improve people's access and health outcomes. The Strategy will be supported by an implementation plan.

2. Chronic Conditions Care Strategy Vision

WAPHA aims to make high-quality person-centred primary health care more accessible, timely, integrated, and easier to navigate for those people with chronic conditions, those who care for them, and those who need it the most[1].

3. Chronic Conditions Care Guiding Principles

The following guiding principles describe WAPHA's intentions for chronic conditions care. These principles should be considered in tandem with the WAPHA Strategic Plan 2023-2026 guiding principles.

WAPHA will:

1. Focus on person-centred primary health care that improves consumer experience and health outcomes.
2. Direct funded services and primary care activities towards individuals and priority population groups that are at disproportionate and inequitable risk of poor health outcomes.
3. Support place-based service integration, care coordination and partnerships wherever possible, to reduce duplication of services and improve patient experience.
4. Promote use of multidisciplinary teams and collaborative care.
5. Build workforce capacity and capability, in the primary care setting, to manage chronic conditions care.
6. Embed a focus on cultural competence, inclusion, and diversity.

1 Priority populations & places - People who are hardest to reach, have inadequate access to primary health care and are most at risk of poorer health outcomes, and the places in which they live *WAPHA Strategic Plan 2023-2026*

4. Chronic Conditions Care Priorities:

People with one or more chronic conditions* who use WAPHA funded or supported care should:

1. Receive culturally and clinically safe, accredited, high quality, person-centred services/care.
2. Receive integrated, accessible, and coordinated care to meet the diverse needs of individuals and the community, as close to home as possible.
3. Receive care early and be supported to self-manage their conditions (where appropriate) to reduce the progression of their chronic conditions for a defined episode of care.
4. Receive comprehensive team based/multidisciplinary primary care to maximise their health outcomes and prevent unnecessary ED attendances and hospitalisations.
5. Receive care from skilled service providers who are supported to build their capacity to provide integrated, person centred chronic condition care.
6. Receive care from service providers who communicate and share timely, secure information, as required.
7. Receive high quality evidence based care with consideration given to data, stakeholder** feedback; and
8. Receive value based, sustainable care, provided within the available budget, including the use of digital technology such as telehealth and other online services where appropriate.

** People with chronic conditions in this context refers to WAPHA's identified priority population in priority locations, informed by qualitative and quantitative data.*

*** Stakeholder feedback includes consumers/patients and service providers.*

5. WAPHA Chronic Conditions Care Strategic Directions:

WAPHA proposes to deliver its chronic conditions care priorities through a series of actions that will support each strategic direction.

5.1. Commission chronic conditions care services, to respond to local needs, that:

a. Address identified chronic conditions care service gaps, through WAPHA needs assessments, data and stakeholder feedback.
b. Are articulated in a triennial chronic conditions care commissioning plan that demonstrates value to the user and community, with clear expectations, requirements, regular measurement, and constructive feedback on performance which includes patient and provider feedback.
c. Focus on priority chronic conditions, locations and population groups, with an equity lens.
d. Demonstrate person centered care and integrated service delivery.
e. Are safe and sustainably delivered within the health system, by accredited and trained providers.
f. Can demonstrate culturally competent carers are working towards providing a culturally safe service.
g. Support Aboriginal community controlled health services to increase capacity and deliver chronic conditions care services to their local communities.

5.2. Foster integration, communication, collaboration and partnerships that:

a. Establish engaged leadership across key partners to actively supports improved system integration and advocates for communities and chronic conditions care WAPHA service providers.
b. Clearly delineate roles and responsibilities of all key organisations for chronic conditions management within each of WAPHA's Primary Health Networks.

c. Supports seamless, coordinated service provision, as close to home as possible.
d. Promote warm referrals and active navigation for priority populations to ensure that their social, physical, and emotional needs are addressed through other community based programs. This includes planned programs/services for those with mental health challenges and one or more chronic physical conditions.
e. Increase access to culturally safe services through clear guidelines and associated training and quality improvement support.
f. Co-design and partner with health service providers to deliver innovative and sustainable models of chronic conditions care.
g. Facilitate sharing of data and information to understand health needs, system performance, service priorities and care provided.
h. Agrees and promotes evidence based chronic conditions care clinical pathways for clinicians.
i. Promotes and provides regular up to date information on current chronic conditions care services and activities to stakeholders.

5.3. Work with consumers/clients/patients to reflect their needs and expected outcomes, in the development and implementation of chronic conditions care services by:

a. Delivering inclusive care to individual, carers, families, support network and community (natural supports) that ensures physical, emotional and mental health needs are being met.
b. Partnering with consumers/patients to design, implement and evaluate primary care services, programs, and activities.
c. Work alongside partner organisations to support people to understand information about health and health care, to apply that information to their lives and to use it to make decisions and take actions related to their health and wellbeing.
d. Supporting patients/clients and communities to work with the chronic conditions care workforce to achieve cultural competency and deliver culturally safe services, as determined service users.
e. Supporting patients/clients to self-manage throughout their episodes of care, including joint decision making, care planning, goal setting and assessment of readiness to change.
f. Providing information that increases community and individual understanding of health conditions, care, services and the health system through interpreters, information in multiple languages, education, and media.

5.4. Build a skilled and sustainable chronic conditions care workforce that:

a. Builds leadership and a safe, equitable culture in healthcare.
b. Partners with other organisations to foster the development of a suitably trained, knowledgeable, resourced, and distributed chronic conditions care primary care workforce in Western Australia.
c. Supports primary health professionals to work to their full scope of practice.
d. Supports innovative workforce models and solutions and implementation of new workforce roles in the health system to improve chronic conditions care effectiveness and efficiency.
e. Supports the implementation of multidisciplinary, team based care models in primary health care.

5.5. Facilitate digital health solutions to support clients and providers of chronic conditions care services that:

a. Enable the use of consistent, timely, high quality data for primary care service quality improvement, monitoring, and chronic conditions improvement (e.g., Primary Sense).
b. Enable the use of effective, accessible, and innovative technology (e.g., telehealth, phone coaching, real time monitoring) by health professionals and patients/clients to improve chronic conditions management and expand the reach of service provision.
c. Facilitate secure sharing of key health information between providers as a high priority.

5.6. Work with general practice to provide a safe, sustainable and high quality service, focused on better health outcomes by:

a. Facilitating quality improvement activities to enhance the management of chronic conditions within the primary care setting.

b. Supporting the delivery of multidisciplinary care within the practice setting through roles such as practice nurses, non-prescribing pharmacists, social workers, and nurse practitioners.

c. Supporting the provision of relevant, up to date data and information to provide enhanced care through recalls, reminders, alerts, MBS items, clinical and referral pathways. This includes timely access to specialist advice relating to the care of patients with chronic conditions. through WAPHA resources including Clinician Assist, Practice Assist, and health professional focused publications.

d. Supporting continuity of care through promoting voluntary patient enrolment and facilitating the implementation of other *Strengthening Medicare Reform measures.*

e. Providing GP and primary health care grant programs to build capacity to deliver person centered, integrated care.

f. Collaboration with general practices to develop local service delivery models, conduct audits and cycles of care for priority chronic conditions in their location.

g. Providing resources to build knowledge and support improved person-centred care including chronic disease management plans, goal setting, health assessments and health literacy tools.

h. Advocating for increased, sustainable primary care funding and models of care, to improve access to chronic conditions management in the community, particularly for WAPHA priority populations.

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Published March 2025

Acknowledgements

WA Primary Health Alliance acknowledges and pays respect to the Traditional Owners and Elders of this country and recognises the significant importance of their cultural heritage, values and beliefs and how these contribute to the positive health and wellbeing of the whole community.

With acknowledgement to Western Vic Primary Health Network Service Delivery Model Regional Care Partnerships: Chronic Conditions 05 December 2022.

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