Government of **Western Australia**
South Metropolitan Health Service

SMHS Older Adult Health Hub

17 September 2026

Olivia Donjerkovich – Care Navigator
Lana Hawkes – Care Navigator



OAHH Clinical Nurse Lorna Hardy and patient



Background

Election Commitment: Older Adult Health Hubs

Integrated community-based care, supporting better outcomes for older adults and reducing reliance on hospital services.

GOVERNMENT COMMITMENT AND STRATEGIC ALIGNMENT



Aligned with:

- Healthy at Home Strategy 2025-2030
- WA Ambulance ramping Strategy
- Older Adult System of Care 2023

OLDER ADULT HEALTH HUBS



- Short term
- Multidisciplinary care
- Delivered in partnership with GPs

BETTER OUTCOMES FOR OLDER ADULTS



- Care closer to home
- Improved patient experience
- Reduced reliance on hospital services
- Promotes coordinated care

Service Delivery – Operating Ethos

The Older Adult Health Hubs will align to the following Operating Ethos:



Easy to Get the Right Care

- No wrong door- all referrals will be acknowledged and directed to the right service in a consistent, timely and responsive manner.
- Where appropriate referrals are outside the target cohort or existing pathways, they will be redirected to the correct service.
- Efforts are made to reduce barriers for patients, carers, and referring clinicians, ensuring older adults receive the right care at the right time.



Holistic Support with Family and Carers

- Person-centred care is delivered with a focus on the older adult's goals, values and preferences.
- Medical and social needs will be addressed together (e.g. housing, transport, finances, isolation) to support wellbeing and independence.
- Families and carers will be actively engaged in care planning, decision-making, and education.



Linkages between Hubs and Services

- OAHHs will operate as a collective with links to both local Health Service Providers and State Based Services.
- If a patient lives outside a hub's catchment, the OAHH will provide care and arrange a coordinated handover to services for ongoing support as required.
- OAHHs will establish strong relationships with local GP services, aged care providers, social supports, and Non-Government Organisations to enable coordinated wrap-around care.



Safe and inclusive physical environment

- Environments will be designed to support wayfinding, reduce confusion, and create a calm, safe atmosphere for older adults with cognitive impairment.
- The built environment will take into consideration the needs of the target cohort to reduce risk of injury and support independence.
- Facilities will be physically accessible to those with mobility limitations, sensory impairments, and other age-related needs.



Safe and inclusive care environment

- Services will be designed to meet the needs of diverse older adult populations, ensuring care is tailored to priority cohorts and delivered with equity and dignity.

Workforce

Medical	Care Navigation	Nursing	Allied Health	Support
Geriatrician	Care Navigators	Clinical Nurse Specialist	Clinical Psychologist	Service Manager
Older Adult Psychiatrist		Clinical Nurse Specialist- Mental Health	Dietitian	Administrative Officers
Palliative Care Consultant		Aboriginal Health Practitioner	Occupational Therapist	
GP			Non clinical aged care assessor	
			Pharmacist	
			Physiotherapist	
			Social Worker	
			Speech Pathologist	

OAHH services

Clinical Care

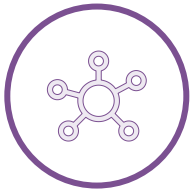
Geriatric
Mental Health
Bone Health.

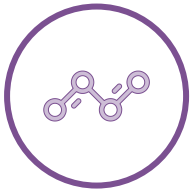




Community Partnerships

Care Navigation





Group Programs

OAHH Team – March 2026



Services

Referral pathways

Eligibility considerations	How to refer
• Functional decline • Increased care needs • Frequent health utilisation • Cognitive concerns • Social factors affecting health / safety Does not replace CRS pathway	Phone: 1300 229 080 Healthlink (SMHS: oahubsth) Email (encrypted) olderadulthhubsouth@health.wa.gov.au Fax: 6174 2022 (attention to OAH Hub)
Consider alternatives if • Needing acute, urgent or emergency medical / mental health care • Likely to require long term specialist input • <65 (<50 ATSI) without geriatric conditions • In permanent care	More information Call **1300 229 080** for advice or scan the QR codes below. SMHS Older Adult Health Hub referrals Healthy WA

OFFICIAL

Geriatric Stream- case study

Referral

88 year old lady Referred by GP for opinion and management of high blood pressure, osteoporosis, osteoarthritis, chronic kidney disease, falls. **Reduced social interaction.**

Care

Geriatrician: comprehensive geriatric assessment

Physio: vestibular assessment and management

Social worker: MAC referral and support

Service Linkage

MAC referral

Commonwealth Home Support Program



Outcome

Improvement in BPPV, sleep

Cardiac investigations ruled out other causes for dizziness.

Anxiety improved and more able to engage in social activities

Recommendation for Mental Health plan to engage in Psychological therapy.

Feedback

I was able to go out and have coffee with my friends twice in the last couple of weeks.

Mental Health Pathway- case study

Referral

66yo with diagnosis of Alzheimers Dementia. Escalating agitation, pre-existing anxiety.

Recent ED presentation

(referral forwarded from Fremantle Older Adult Mental Health Service)

Care

Psychiatrist:
Psychoeducation.
Medication adjustments and titration.

Care Navigation:
Carer support
Service linkages and navigation

Service Linkage

- Dementia Australia
- McKusker Nurse- facilitated peer support relationship
- Carers WA
- Fit for life programs



Outcome

Wife feeling more confident using behavioural strategies and when to escalate to medication as needed.

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Care Navigation- case study

Referral

Patient known to another health service, moved to SMHS catchment, **lost to follow up**.

Significant functional decline related to peripheral neuropathy post cancer treatment

Care fragmentation due to lack of shared records and multiple providers

Care

Care Navigation: Cockburn community lifestyle dietetics, MAC referral, provided local GP and Physiotherapy providers, provided information on EPA and EPG, referral forms for community transport. Collation of private medical documentation for transfer to local GP, encouraged to utilise My Health Record.

OT: equipment provided

PT: Referred to FH MSK physio service

Pharmacist: assessment and collation of medical records, recommendations to GP to reduce high risk medications. Facilitated safe disposal of medications.

Service Linkage

Cockburn healthy lifestyle

MAC

Community transport

Attended Palliative Care WA workshops

Feedback

blown away by what can be achieved when people care- thank you for caring about my sister

OFFICIAL

Care Navigation- case study

Referral

67 year old male with a history of Charcot Marie Tooth Disease, **C3/4 spinal cord injury and poorly managed diabetes**

Referred by GP for support with **pain** management, **sleep** disturbance**, carer** challenges supporting **mobility,** risk of pressure sores, **recurrent UTI's, delirium and sepsis.**

Care

Care Navigation: Collateral Hx, onward referral to Conect for medical care coordination.

Geriatrician: cognitive work up, medication recommendations (blood sugar/ pain Mx, hallucinations), referred to spinal outreach and chronic pain service.

Pharmacist: Home medicine review. Recommendations sent back to GP.

Dietetics: education and support for diabetes management.

Service Linkage

FSH Spinal Outreach service

Rehabilitation medicine

Spinal Urology

CoNeCT

Outcome

Neurodegenerative process excluded
No further hallucinations
Pressure injury resolved
Blood sugars
Linked in with appropriate health services for ongoing management

Group programs



Lorna (Nurse) and Deirdre (Pharmacist) delivering 'Managing your Medications' and 'Managing Chronic Health Conditions' Education Session

- Falls prevention
- Exercise
- Nutrition and healthy eating
- Continence management
- Brain health
- Pacing, sleep and mental wellbeing
- Managing chronic conditions
- Bone health
- Managing medications
- Advanced Care Planning

"I really found the session very informative and enjoyable and interactive as I was able to have questions answered as we went along"

"The talks were great and inspiring"

"Found everything to be explained very well and easy to follow"

"Enjoyed the discussions during session"

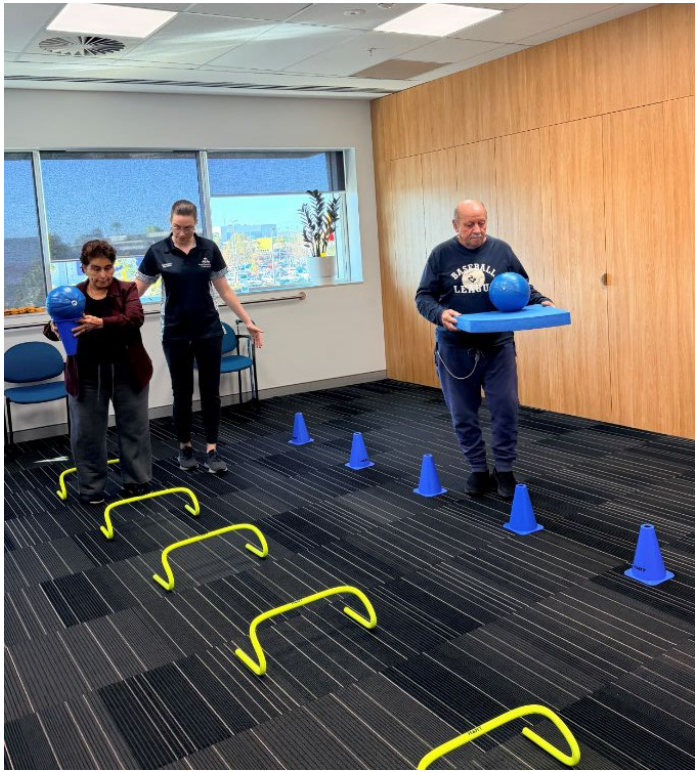
"Very qualified and interesting people presenting the talk"

Group programs



The SMHS OAHH partnership with Palliative Care WA has run seven Advance Care Planning Workshops with 31 attendees. There have been five Advance Health Directive Workshops with 13 attendees.

Advance Care Planning: Palliative Care WA



Patient exercise groups with Kat (Physio)

Community Partnerships





The SMHS OAHH team with attendees and Chung Wah and Freo Men's Shed community events.



Achievements to date

What has been achieved - feedback



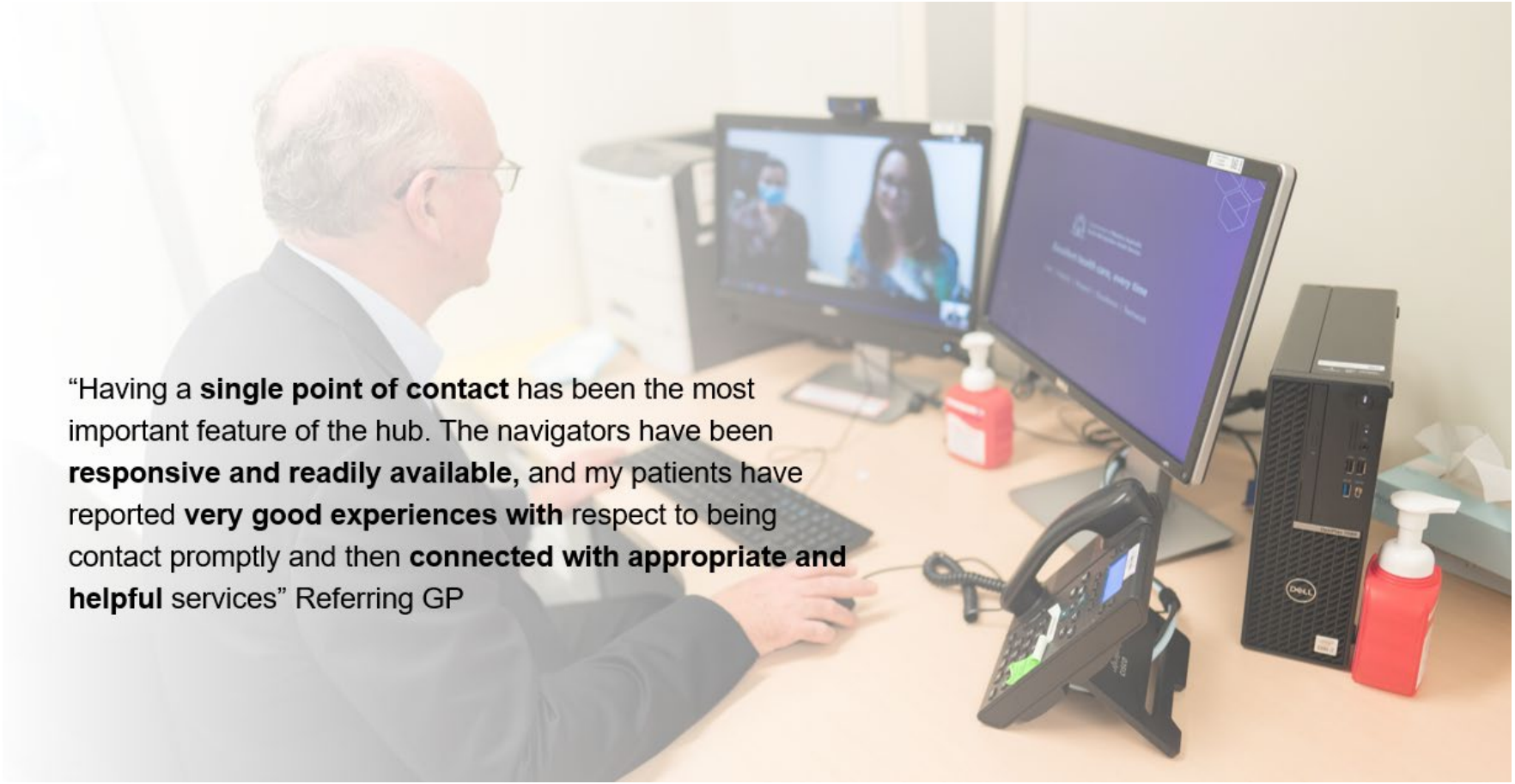
"The hub has been **the greatest thing** for my mum, my mother-in-law and I.

Before I had no help, but these girls have been awesome. They have been **helping me to get the funding and support** that I need to care for my mum and mother-in-law

They have referred us to doctors and physios to continence specialist and **have been guiding us** through all the My Aged Care stuff and SilverChain.

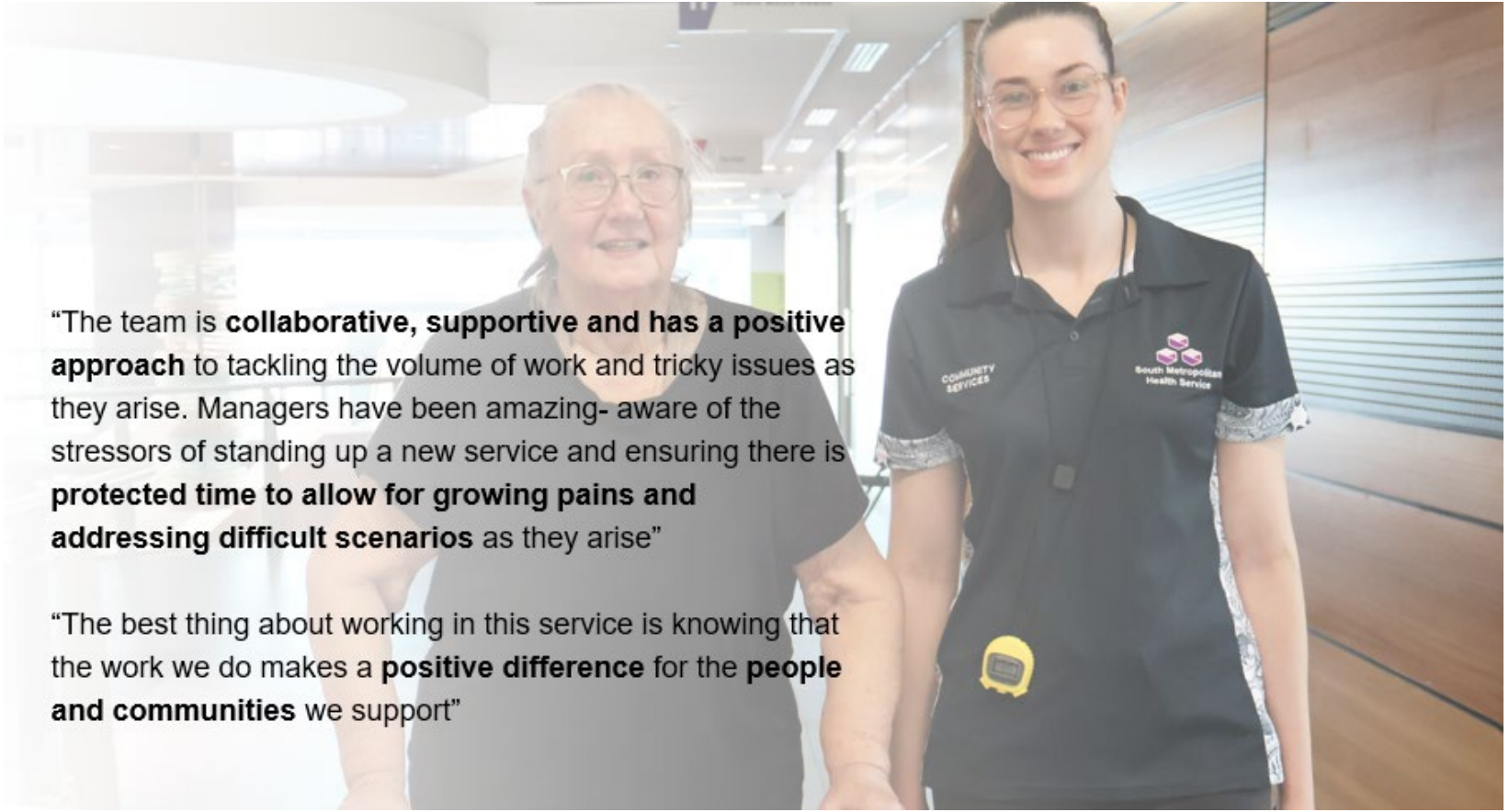
It's been really good for me and my mums, and **everything feels more together** and in place. I am so grateful for the service they have provided." Carer

What has been achieved- feedback



"Having a **single point of contact** has been the most important feature of the hub. The navigators have been **responsive and readily available,** and my patients have reported **very good experiences with** respect to being contact promptly and then **connected with appropriate and helpful** services" Referring GP

What has been achieved- workforce



"The team is **collaborative, supportive and has a positive approach** to tackling the volume of work and tricky issues as they arise. Managers have been amazing- aware of the stressors of standing up a new service and ensuring there is **protected time to allow for growing pains and addressing difficult scenarios** as they arise"

"The best thing about working in this service is knowing that the work we do makes a **positive difference** for the **people and communities** we support"



Thank you