Primary Health Network role in Advance Care Planning

Primary Health Networks (PHN) can play a key role in supporting both health care providers and the local community in Advance Care Planning (ACP). This can be done by integrating ACP activity into existing program areas and working with others to improve systems and processes for ACP across different settings.

Support local primary and community health care providers:

- ✔ Ensure access to ACP education and training (both 'basic' and 'champion' level training)
- ✔ Provide access to resources and tools to implement ACP as part of usual practice
- ✔ Facilitate engagement with hospital ACP programs and across health care settings
- ✔ Support improvements in systems for integration and transfer of ACP information (e.g. eHealth)
- ✔ Act as advocate to state and federal departments of health regarding ACP-related issues that affect primary health care providers and their patients/clients in the PHN region

Support local community members:

- ✔ Help increase the knowledge and skills of health and community care providers – to support their patients and clients
- ✔ Ensure appropriate ACP information is available to the community – e.g. by working with other health care organisations, service providers, consumer groups, community organisations and local councils
- ✔ Act as advocate to state and federal government departments regarding ACP-related community issues identified in the PHN region

> **"The collaborative approach offered the opportunity to find out/understand how different service areas relate to ACP, how the community fits in, compare notes in terms of challenges, successes and strategies, and develop a common plan of action in order to promote ACP.**

Strategies for supporting ACP in primary health networks

1. Establish robust systems

- ☐ Use a collaborative, whole-of-life approach. Integrate ACP across relevant programs, e.g.
  - *Older persons/Aged Care*
  - *General Practice Support*
  - *Chronic Disease Management*
  - *Nursing in General Practice*
  - *Consumer engagement*
  - *Allied Health Support*
  - *Acute-primary interface*
  - *HealthPathways*
  - *eHealth*
- ☐ Work closely with local hospitals and other providers to improve transferability of ACP across settings
- ☐ Support health and care services to develop robust ACP systems
- ☐ Support inter-sectoral system improvement

2. Evidence and quality

- ☐ Base policy and project/program activity on evidence
- ☐ Link with accreditation standards for organisations supported by PHN
- ☐ Develop appropriate measures for monitoring impact of ACP activity

  e.g. Monitor number of people and roles receiving training/education, surveys for attendees before and after education events to monitor change in knowledge and confidence, monitor number of organisations supported in ACP, monitor usage of the ACP HealthPathway
- ☐ Support local health providers' access to evidence for ACP

"It was useful to be able to see what other sectors were experiencing and what the barriers were and how other people were dealing with these issues.

3. Workforce capability

- ☐ Multiple online and face-to-face ACP and palliative care education opportunities may be available through other organisations. To make the most of available resources:
  - Work with other organisations to identify quality education, training and professional development opportunities
  - Routinely integrate ACP awareness into education forums, e.g. dementia updates, chronic disease, palliative care forums
  - Ensure access to multi-disciplinary education for ACP 'champions' as well as basic ACP education
  - Provide access to information regarding legal frameworks and implementation steps
  - Use ACP HealthPathway* or other key ACP resources to support health and care professionals
  - Support access to education and training to boost skills in palliative and end-of-life care and enable more ACP

4. Enabling the person

- ☐ Work with local community organisations to ensure consumer groups have access to information and support
- ☐ Utilise a person-centred approach
- ☐ Help develop appropriate ACP patient resources
- ☐ Support MTDM/SDM/family to ensure they understand their role and the person's preferences
- ☐ Promote multiple opportunities for ACP discussions
- ☐ Identify and promote linkages for patients and families to obtain other support services
  - Usual GP/PN
  - Office of the Public Advocate
  - Other local services
- ☐ Support health professionals to use ACP information to inform decision-making when people lose capacity

*HealthPathways Melbourne is a website for health professionals with free, relevant and evidence-based information on the assessment and management of common clinical conditions, including referral guidance.

Go to melbourne.healthpathways.org.au

The Medical Treatment Planning and Decisions Act 2016 (which commenced on 12 March 2018) made some significant changes to medical treatment decision making for people who do not have the capacity to make their own decisions. Visit www2.health.vic.gov.au/Api/downloadmedia/%7B58139B8D-A648-4995-82F6-471129BAC322%7D to find out more.

For More Information

This information sheet is one of seven service setting extracts from the Advance Care Planning - Roles and Responsibilities in Advance Care Planning booklet, developed as part of a collaborative quality improvement project conducted between June 2015 and March 2016.
Visit nwmphn.org.au/clinical-community/advance-care-planning for a copy of the full booklet.

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> It was great to see the cross sectoral commitments. Our organisation has found an increased level of engagement on the topic.

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