Primary Health Networks – Greater Choice for At Home Palliative Care

North Western Melbourne PHN

15 February 2018
Introduction

Overview

The key objectives of Primary Health Networks (PHN) are:

- increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- improving coordination of care to ensure patients receive the right care in the right place at the right time.

The Greater Choice for At Home Palliative Care (GCfAHPC) provides funding to improve coordination and integration of end-of-life care across primary, secondary, tertiary and community health services to support at home palliative care through funding Primary Health Networks (PHNs).

In line with these objectives, the PHN GCfAHPC Funding stream will support PHNs to:

- improve 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 ensure continuous improvement of services across sectors; and
- utilise available technologies to provide flexible and responsive care, including care after usual business hours.

In the context of the PHN GCfAHPC, funding under this stream will support the recruitment of two Full-Time Equivalent positions within the PHN to deliver the activity in accordance with the GCfAHPC Expression of Interest (EOI) submission/proposal and any aspects agreed to during clarification sessions post EOI outcome.

PHNs are required to outline planned activities, milestones and outcomes to provide the Australian Government with visibility as to the activities expected to be undertaken by PHNs selected to implement the GCfAHPC pilot project.

GCfAHPC Activity Work Plan must:

- reflect the individual PHN GCfAHPC Expression of Interest (EOI) proposal and anything agreed to in the clarification sessions post EOI outcome;
- demonstrate to the Australian Government what the PHN is going to achieve and how the PHN plans to achieve this; and
- be developed in consultation with local communities, Clinical Councils, Community Advisory Committees, state/territory governments, Local Hospital Networks/Local Health Districts and other stakeholders, as appropriate.

This GCfAHPC Activity Work Plan covers the palliative care component of Core Funding provided to PHNs to be expended within the period from 1 January 2018 to 30 June 2020.
**Background**
Through an EOI process undertaken in August – September 2017, all 31 PHNs were invited to submit their interest in implementing the GCfAHPC pilot measure. Through this process, 10 PHNs were selected to receive funding to implement the measure.

**Further information**
The following may assist in the preparation of your GCfAHPC Activity Work Plan:

- GCfAHPC measure Communique (provided to PHNs 3 Aug 2017);
- Department of Health website:
  - GCfAHPC measure – Frequently Asked Questions
  - National Palliative Care Projects
  - Key Facts Budget 2017-18 – Greater Choice for At Home Palliative Care measure
  - Decision Assist palliative care and aged care Linkages document

Please contact your Grant Officer if you are having any difficulties completing this document.
1. Planned activities funded under the Activity – Primary Health Networks *Greater Choice for At Home Palliative Care* Funding

<table>
<thead>
<tr>
<th>Proposed Activities</th>
<th>Description</th>
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<tbody>
<tr>
<td>Activity Title</td>
<td>Greater Choice for At Home Palliative Care (GCfAHPC) Project.</td>
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<td>Description of Activity</td>
<td>Recruitment of two Full-time Equivalent (FTE) positions will commence in 2017-18. These roles will use a collaborative approach to realise the GCfAHPC objectives, focussed in the following activity areas:</td>
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<td>• Workforce capacity building, using existing resources</td>
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<td>• Improving care pathways</td>
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<td>• Consumer, carer and family engagement</td>
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<td>• Data driven quality improvement</td>
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<td>• Integrated models of care</td>
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<td>Different approaches will be taken to progress work in each of these areas, utilising and leveraging existing knowledge, resources and relationships.</td>
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<td><strong>Workforce capacity building, using existing resources</strong> – work in this area will include increasing awareness and uptake of existing resources, such as advance care planning and palliative care resources and education programs for health care providers, knowledge exchange and upskilling. NWMPHN will also seek to develop strategies to increase uptake of MBS case conferencing items across community, Residential Aged Care Facilities (RACFs) and GPs. Increased uptake of this item aims to reduce demand for palliative care after usual business hours.</td>
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<td><strong>Care pathways</strong> – work in this area will involve implementing and measuring the impact of advance care planning and recently developed palliative care pathways across the North Western region of Melbourne, in collaboration with key stakeholders/partners. Due to service complexity, further work</td>
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is required to improve integration and therefore streamline the pathways to improve general practice and broader primary care involvement in a palliative approach.

**Consumer, carer and family engagement** NWMPHN will employ a co-design approach to identify how to better support consumers, carers and families to increase access to palliative care at home. This approach will include utilising existing data and literature.

**Data driven quality improvement** – NWMPHN staff will collaborate with key stakeholders/partners and general practice teams to understand what data is currently collected across the sector, including data quality, to establish a baseline and a plan for measuring performance and outcomes.

**Integrated models of care** – NWMPHN will develop and implement strategies to connect services, which may include care navigation (building on the work being undertaken to pilot care navigation models in chronic conditions, alcohol and other drugs and mental health) and role clarification across multidisciplinary team structures, settings and organisations.

Please note, a description of how the above activity areas will achieve the objectives of the GCfAHPC project is outlined in the Strategic Alignment section below.

NWMPHN will work with partners through existing governance structures, allowing for shared capability and accountability across the sector, including:

- The North and West Metropolitan Region Palliative Care Consortium, which includes a Managers Committee, with representation from each member organisation (including multiple local hospital networks such as The Royal Melbourne Hospital, Victorian Comprehensive Cancer Centre, Western Health and community palliative care and domiciliary nursing services) and a Clinical Advisory Committee with representation from partner organisations.
- Local Hospital Network and primary care collaborative structures, such as The Collaborative, which have well established authorising and monitoring environments.
- Advice will be sought from the NWMPHN Clinical and Community Advisory Councils in the development and implementation of this initiative.
- Existing and emerging Expert Advisory Groups such as the Mental Health, Alcohol and Other Drug, LGBTIQ Taskforce will also be asked to provide input to this initiative.
### Rationale/Aim of the Activity

**Aim:** The aim of the GCfAHPC funding is to improve coordination and integration of end of life care across primary, secondary, tertiary and community health services to support at home palliative care.

**Rationale:** There are multiple hospital and community services providing specialist palliative care across the North Western Melbourne region, including medical deputising services, over 500 general practices and more than 130 RACFs. This complexity leads to fragmentation and creates barriers for general practitioners (GPs) to be more actively involved in the provision of palliative care in the home. This complexity also makes it difficult for patients to navigate the service system to access safe, high quality palliative care at home.

### Strategic Alignment

NWMPHN’s approach for the GCFAHPC project is closely aligned with the PHN programme objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and improving coordination of care to ensure patients receive the right care in the right place, at the right time.

Planned activity aligns with the four objectives of the GCFAHPC project as follows:

**Objective 1:** improve access to safe, quality palliative care at home and support end-of-life care systems and services in primary health care and community care

NWMPHN will seek to increase **workforce capacity** and confidence of primary health care and community care providers to engage earlier with patients who need palliative care and improve referrals to palliative care services to better support palliative care at home. This will contribute to improving access to safe, quality palliative care at home.

Through the development and implementation of **integrated models of care**, NWMPHN will drive end-of-life care service and system improvement.

**Objective 2:** enable the right care, at the right time and in the right place to reduce unnecessary hospitalisations

Building **workforce capacity** and **integrated models of care** will contribute to ensuring that consumers are provided with the right care at the right time and in the right place, and may in turn contribute to a reduction in unnecessary palliative care-related hospitalisations.

**Consumer, carer and family engagement** will help NWMPHN to understand how to improve access to palliative care at home for consumers, carers and families. This will contribute to
ensuring that consumers are provided with the right care at the right time and in the right place, and may in turn contribute to a reduction in unnecessary palliative care-related hospitalisations.

Implementation of primary care focused advance care planning and palliative care pathways and building on the learnings from care navigation pilots will seek to improve integration and therefore streamline the pathways to improve general practice and broader primary care involvement in a palliative approach. This will also contribute to ensuring that consumers are provided with the right care at the right time and in the right place, and may in turn contribute to a reduction in unnecessary palliative care-related hospitalisations.

**Objective 3: generate and use data to ensure continuous improvement of services across sectors**

Data driven quality improvement will involve NWMPHN staff collaborating with key stakeholders/partners and general practice teams to establish a baseline and use this data to inform continuous improvement of services.

**Objective 4: utilise available technologies to provide flexible and responsive care, including care after usual business hours.**

NWMPHN will utilise appropriate strategies and technologies including building on care navigation pilots and HealthPathways to seek to improve integration and therefore streamline care pathways to improve general practice and broader primary care involvement in a palliative approach. This will contribute to enabling primary health care and community care providers to support at home palliative care during and after usual business hours.

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<th>Scalability</th>
<th>The outcomes/findings from NWMPHN’s GCAHPC work that could be scaled across the NWMPHN region or transferred to other PHN regions may include:</th>
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<td>- integrated models of care;</td>
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<td>- practice and system level quality improvement initiatives;</td>
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<td>- multidisciplinary team structures across sectors;</td>
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<td>- knowledge exchange and upskilling; and</td>
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<td>- role clarification across settings/organisations.</td>
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<td>It should be noted that applicability/relevance of NWMPHN’s work in this area to other PHN regions will depend on the context/settings in these regions – for example, community palliative care arrangements may be different in other states.</td>
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<p>| Target Population | People with a known life-limiting condition and their families; people living with chronic conditions, including cancer; and areas that have lower rates of dying at home. |</p>
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<tr>
<th>Coverage</th>
<th>NWMPHN region.</th>
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<td>Anticipated Outcomes</td>
<td>The intended long-term outcome of all activity is to improve access to palliative care at home. NWMPHN has adopted a medium-term outcome to facilitate a more timely indicator of progress. This medium-term outcome is to improve referral processes for, and confidence of, primary health care and community care providers in palliative care at home.</td>
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| Measuring outcomes | Measures as per above outcomes:  
1. Number of referrals received from GPs to specialist palliative care services (pre- and post-intervention).  
2. Number of GPs reporting perceived increased confidence in palliative care management (survey).  
3. Palliative Care specific admissions (from the Victorian Admitted Episodes Dataset) to establish a baseline in order to be able to measure impact of the project in the longer term |
| Indigenous Specific | No. |
| Collaboration/Communication | NWMPHN recognises that working collaboratively adds value and strengthens our reach. Consequently, NWMPHN has built strong collaborative relationships with a range of key stakeholders, including but not limited to Palliative Care Victoria, Centre for Palliative Care, Program of Experience in the Palliative Approach, and the North and West Metropolitan Region Palliative Care Consortium (NWMRPCC). Additional collaboration and communication options include:  
- NWMPHN Clinical and Community Advisory Councils  
- NWMPHN Expert Advisory Groups (e.g. Mental Health, AOD and LGBTIQ etc.)  
- Collaborative structures – including North and West Metropolitan Region Palliative Care Consortium (NWMPHN is a member); Victorian PHN Alliance Palliative Care and Advance Care Planning Community of Practice (NWMPHN convenes this group); The Collaborative (NWMPHN is one of four organisation in this partnership) Melbourne Ageing Research Collaboration (MARC) (NWMPHN is a member).  
- Partnership organisations (for example Carer Links North and the NWMRPCC) that have established robust community engagement frameworks  
- Primary care and community palliative care providers |
| Timeline | Recruitment and onboarding |
### Risk Management

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<th>Risk</th>
<th>Mitigation</th>
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| Limited stakeholder engagement |  - Develop a clear and robust engagement strategy as part of the co-design process.  
- Build on existing relationships with stakeholders that are highly engaged.  
- Provide appropriate support and single point of contact for stakeholders with a dedicated PHN staff member. |
| Outcomes are achievable within timeframes |  - Ensure goals/activities are specific, measurable, achievable, relevant and time bound, informed by clinical and community input.  
- Ensure activity complements and integrates with existing NWMPHN work where appropriate. |
| Complexity of the palliative care service system with the NWMPHN region |  - Ensure goals/activities are specific, measurable, achievable, relevant and time bound, informed by clinical and community input.  
- Ensure activity complements existing NWMPHN work where appropriate.  
- Target specific cohorts of consumers and carers across the NWMPHN catchment. |
| Sustainability |  - Ensure the question of sustainability is incorporated into planning, prioritisation and implementation phases of this work. |