Australian Government
Department of Health

phn
An Australian Government Initiative

# Primary Health Networks – *Greater Choice for At Home Palliative Care*

## *Eastern Melbourne PHN*

**When submitting the *Greater Choice for At Home Palliative Care* Activity Work Plan 2017-2018 to 2019-2020 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and has been endorsed by the CEO.**

**The *Greater Choice for At Home Palliative Care* Activity Work Plan must be lodged to Rosie Tira via email to VicPHN@health.gov.au on or before 17 February 2018, and subsequently updated, on an annual basis.**

# 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

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2017-18 to 2019-2020 These activities will be funded under the *Greater Choice for At Home Palliative Care* Funding stream under the Schedule – Primary Health Networks Core Funding.

Instructions: please delete instructions (in blue font) within the 'Description' column before submitting to the Department, but do not delete or remove any text (in black font) in the Activity Work Plan template. Text in black font indicates information that has been pre-populated and must be retained in the Activity Work Plan. Also, do not alter the structure of the table (i.e. do not add/delete columns/rows, or insert tables/graphs), unless specifically instructed to, e.g. Risk Management

| Proposed Activities | Description |
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| Activity Title | *Greater Choice for At Home Palliative Care* (GCfAHPC) Project.<br><br>Making it Possible – Greater Choice for At Home Palliative Care |
| Description of Activity | Two project roles will be employed to undertake the activities required under the Greater Choice for At Home Palliative Care funding:<br><br>• Project Facilitator (1.0 FTE) with responsibility for leading the working groups, broad stakeholder engagement and relationships and ensuring implementation of projects that are occurring or are developed, and<br><br>• Project Officer (1.0 FTE) to work on data collection and analysis, to understand the depth of the problem and gaps identified, and as project support to assist with implementation of working group activities.<br><br>Governance for the Greater Choice for at Home Palliative Care will be overseen by the Executive Director, Integrated Care (Figure 1). |

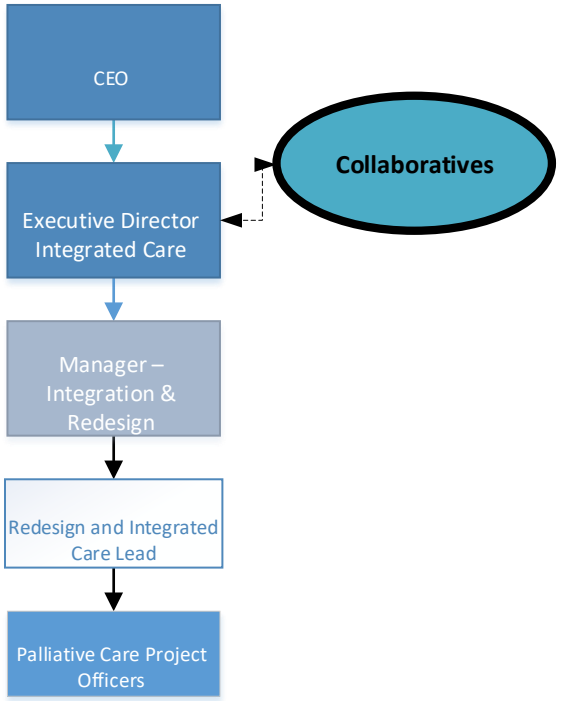


Figure 1.

The project roles will employed within the Integrated Care Team and directly report to the Lead, Redesign and Integrated Care. The two positions will work closely with other relevant teams within and outside Eastern Melbourne PHN, including:

- Collaborative Executive Officers,
- Sector Capacity,
- Health Pathways,
- After Hours and Workforce and
- Development teams.

To achieve the measure we will implement programs to:

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| | 1. Deliver an individual case based approach for in-home support to improve the skills and confidence of GPs and staff in aged care. The approach will provide a hospital based support to manage particular patients;<br>2. Use human resources and/or technological approaches to provide care at home, particularly after hours;<br>3. Increase the number of Advance Care Plans being completed in the community<br>4. Improve education for GPs, community service providers and volunteers assisting palliative care patients in the community using programs including Program of Experience in the Palliative Approach (PEPA);<br>5. Integrate services that exist in the after-hours period, with a particular focus on GP deputising services;<br>6. Focus on ensuring more people are able to die in their place of choice or remain in their home as long as possible; and<br>7. Promote the increased use of HealthPathways Melbourne, which has a comprehensive suite of palliative care pathways, to provide comprehensive clinical decision-making tools and referral pathways for GPs.<br><br>Eastern Melbourne PHN has developed strong links with the health providers across the catchment to enable a consistent approach to system improvement by developing region wide platforms of service providers and organisations focused on primary health care system collaboration. These structures referred to as 'Collaboratives', include Eastern Melbourne Primary Health Care Collaborative (EMPHCC) in the East, and Better Health North East Melbourne (BHNEM) in the North, will enable the PHN to work closely with the service providers to implement the activities under the Greater Choice for at home Palliative Care program across the entire catchment.<br><br>We will take an Action Research approach to improve capacity within our catchment to deliver palliative care services to people in their homes. Using this methodology will ensure a collaborative approach to a continuous cycle of improvement. This is consistent with the PHN's Commissioning Framework, which will support any collaborative driven projects that require additional funding.<br><br>The EMPHCC has established an End of Life Care (EoLC) Working Group that has identified a lack of integrated data collection as an issue. Data will be sourced from partner organisations, including RACFs, local hospitals and palliative care providers. The Project Officer will ensure data is collated, shared and used to inform the activities of the working groups. Data collection will include: |

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| | • service mapping information;<br>• statistical and demographic data;<br>• increased palliative care provision at home;<br>• averted emergency presentations and inpatient admissions;<br>• increased advance care plans completed and registered;<br>• patient journey understanding and experience; and<br>• service/hospital presentation data.<br><br>This link provides access to the Project Activity Description Summary. |
| Rationale/Aim of the Activity | End of life care is a well-recognised priority area, both nationally and locally, with Australia's rate of dying at home being comparatively low compared with other similar OECD countries. The Grattan Institute report, Dying Well (Swerrissen and Duckett, 2014) states "in the next 25 years the number of Australians who die each year will double. People want to die comfortably at home, supported by family and friends and effective services." Whilst acknowledging that people want to be able to die in their place of choice, there are numerous factors that preclude this from happening for many people.<br><br>In June 2016 EMPHN undertook a workshop in the Eastern region of the catchment, to engage a broad range of stakeholders in understanding the issues that prevent people in the catchment from being able to die in their place of choice. The workshop identified key themes that included:<br><br>1. **Training and education** – for staff of both community and acute care facilities, and families – across all phases of end of life care. Topics include death literacy in the community, community awareness to make informed choices and carer capability to deliver person's choice<br>2. **Service gaps** – interagency coordination and communication channels – at transition of care, after hours access to services.<br>3. **Services for carers** throughout whole process – by all service providers, bereavement support<br>4. Individualised holistic care – including isolated/difficult to reach people/cultural and ethical issues/disabilities<br>5. **Availability of resources to support people to die in their place of choice** – physical (equipment etc.) and financial |

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| | 6. **Staff and/or family unwillingness/ability to follow EOLC plans** – resources, practicality, knowledge, capability, comfortable with choices<br>**7. Variation in understanding of patient centred care**<br>8. **Staffing skill mix to provide EOLC in Aged Care facilities** – adequate staff skills in RACF to manage palliative care<br>9. **Staff recognising end of life** and then being comfortable with having appropriate discussions with families – identification of dying, the timing of the conversations and all options being discussed, cultural differences around language<br>10. **Advanced Care Plans** – ensuring the 'where' is part of the planning – not just 'how'<br><br>The learnings from this workshop have informed the work of the Eastern Melbourne Primary Health Care Consortium End of Life Care working group. A similar approach will be undertaken in the remaining regions of the EMPHN catchment. |
| Strategic Alignment | This activity will ensure people have the right care in the right place at the right time, at the most important time, by improving the coordination of care for people at the end of life.<br><br>End of life care and palliative care are identified as areas of need in the PHN needs assessment, particularly in the after hours period. The needs assessment also identifies poor locum GP knowledge of palliative care as a cause of unnecessary hospital transfers. This activity will work with GPs to improve palliative care knowledge. Confidence of hospital and specialist palliative care service providers in GPs is also identified as an issue. Better integration of services across providers and improved work flow and communication will assist in GPs, hospitals and specialist palliative care providers being able to work together, which should increase the number of people who are able to remain at home if that is their wish. |
| Scalability | This activity will be expanded throughout the EMPHN catchment as part of the existing project plan and by working with existing collaborative arrangements. It could then be expanded to other PHNs as required, using the same method of engagement and implementation. It is anticipated this will be nuanced over the course of the project as lessons are learnt. EMPHN staff will be able to clearly articulate the methodology and share this with other PHNs. |
| Target Population | • Consumers. Through this activity, improvements to the palliative care system at end of life will improve the ability for consumers to be able to die in their place of choice. Numbers will be defined through the data analysis part of the project, but a quantifiable increase of people who are able to die in their place of choice will be established.<br>• Carers. Carer stress will be reduced when the system has improved integration. |

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| | • Local hospital clinicians.<br>• Local specialist palliative care providers.<br>• GPs and the general practice team. A key aspect of the project is to better integrate GPs in the end of life and palliative care process. GPs are a key clinical resource for patients and other clinicians and have an integral role to play. This activity will work towards better inclusion and support for GPs and the general practice team (practice nurses). |
| Coverage | This project will cover the entire EMPHN catchment. The activities will be split up regionally to include:<br>Eastern Melbourne: Yarra Ranges, Knox, Manningham, Maroondah, Monash, Whitehorse and Boroondara local government areas.<br>Northern: Banyule, Nillumbik, Whittlesea and parts of Mitchell and Murrindindi local government areas. |
| Anticipated Outcomes | • More people in the EMPHN catchment have a documented advance care plan<br>• More GPs are directly involved in the end of life care of their patients<br>• More people are able to die in their place of choice, where this choice has been documented<br>• Reduction in unnecessary hospitalisations for people with palliative care needs<br>• Carers have improved access to services and support, resulting in fewer hospitalisations occurring due to carer stress |
| Measuring outcomes | • The outcomes listed below align with the outcomes under the Evaluation Framework developed by Deloitte Access Economics under stream 3 – Capacity building among palliative care providers.<br>• Number of people with a documented advance care plan<br>• % increase compared with baseline of number of people with a documented advance care plan<br>• Number of GPs providing end of life care<br>• % increase compared with known baseline of GPs providing end of life care<br>• Number of people who die at home, in hospital, in a RACF or other setting<br>• Comparison of where people die with their documented wished place of death<br>• % improvement of people who die in their place of choice<br>• Number of hospitalisations for palliative care that could have been managed in the community |

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| | • Carer satisfaction and experience<br>• Clinician satisfaction and experience |
| Indigenous Specific | This activity is not specifically targeted at Aboriginal and Torres Strait Islander people. EMPHN will ensure, however, that the local Aboriginal population is included in this project and that the specific needs of this cohort of patients are identified and considered throughout all elements of the activity. |
| Collaboration/Communication | EMPHN has well established collaborative arrangements in the East and North of our catchment. Through End of Life Care working groups, one of which is established and another to be established, governance arrangements will be put in place through Terms of Reference for each group. In the east, the working group will sit under the Eastern Melbourne Primary Health Care Collaborative. In the north it will be stand alone<br><br>Working groups will include public and private providers, including GPs, aged care facilities and providers, hospitals, specialist palliative care providers, and peak bodies including Palliative Care Victoria. EMPHN will also work with North Western Melbourne PHN, particularly in the northern part of the catchment where we have significant cross over with services and providers. Carer and consumer representation will also be included, when appropriate, with consideration to the delicacy of engaging carers and consumers in end of life discussions.<br><br>EMPHN has letters of support from Monash Health and Palliative Care Victoria and existing collaborative arrangements with Austin Health and Eastern Health. |
| Timeline | April 2018 – Employment of two FTE project staff<br>April 2018 - June 2018 – Comprehensive project and evaluation plan developed<br>November 2018 – End of life care workshop held in Northern Region of catchment<br>February 2019 – First draft of End of life care data report developed<br>June 2019 – Establishment of Northern Region End of Life Care working group and inclusion of Monash Health in the Eastern Metropolitan Region End of Life Care working group.<br><br>August 2019 – Follow up end of life care workshops held in each region |
| Budget (pre-populated) | The PHN 2017-18 to 2019-20 budget for the GCfAHPC Funding stream is provided below.<br>Funding will be provided under the current PHN Core Funding Schedule, with all existing Terms and Conditions, Supplementary Conditions and Terms of Payment remaining. |

| Financial Year | Funding amount (GST Exclusive) | GST component (if applicable) | **Total (GST Inclusive)** |
|---|---|---|---|
| 2017/18 | $150,000.00 | $15,000.00 | **$165,000.00** |
| 2018/19 | $300,000.00 | $30,000.00 | **$330,000.00** |
| 2019/20 | $300,000.00 | $30,000.00 | **$330,000.00** |
| **TOTAL** | **$750,000.00** | **$75,000.00** | **$825,000.00** |

Funding will support the PHN to recruit and employ two Full-time Equivalent (FTE) positions (expenditure on salaries only) to improve coordination and integration of end-of-life care across primary, secondary, tertiary and community health services to support at home palliative care for those that choose it.

EMPHN intends to seek co-investment from Collaborative partners through Eastern Melbourne Primary Health Care Collaborative and other PHN funds in the development of projects identified through this activity.