Australian Government
Department of Health

phn
An Australian Government Initiative

# Primary Health Networks – *Greater Choice for At Home Palliative Care 2020-2021*

***Central Queensland Wide Bay Sunshine Coast PHN***

## Abbreviations

| | |
|---|---|
| ACP | Advanced Care Plan/Planning |
| AHD | Advanced Health Directive |
| CQWBSCPHN | Central Queensland Wide Bay and Sunshine Coast Primary Health Network |
| EOLC | end-of-life care |
| GCfAHPC | Greater Choice for At Home Palliative Care |
| GP | general practitioner |
| HHS | Hospital and Health Service |
| ISC | (Palliative Care) Interagency Steering Committee |
| KPI | key performance indicator |
| OACP | Office of Advanced Care Planning |
| PEPA | Program of Experience in the Palliative Approach |
| RACF | residential aged care facility |

# Introduction

## Overview

The *Greater Choice for At Home Palliative Care* (GCfAHPC) provides funding to improve coordination and integration of end-of-life care (EOLC) 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.

This GCfAHPC activity work plan covers the palliative care component of core funding provided to PHNs to be expended within the period from 1 July 2019 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, 11 PHNs were selected to receive funding to implement the measure.

# 1. Planned activities funded under the Activity – Primary Health Networks *Greater Choice for At Home Palliative Care* Funding

| Proposed Activities | Description |
|---|---|
| Activity Title | *Greater Choice for At Home Palliative Care* (GCfAHPC) Project. |
| Existing, Modified, or New Activity | Existing/Modified |
| Program Key Priority Area | Other – Palliative care |
| Needs Assessment Priority | This project aligns with the Health Needs Assessment. The PHN catchment has high proportions of elderly people. Population projections show that growth rates in the over 65 age group are greater in the PHN region compared to Queensland. By 2021, the PHN population aged 65 and over will be 20.8% compared to Queensland 16.2% (p. 14). With this population growth an increasing number of support services and systems to support older people to continue to live in their homes will be required.<br><br>The number of palliative care-related hospital admissions in the PHN is expected to double from 2013-14 to 2026-27. Issues around availability and access to at home and community palliative care were raised (p. 53). Enhancing workforce skills and capacity in the area of palliative care (p. 53) and enhancing access to and integration of palliative care service (p. 62) were also identified as areas of need. |
| Description of Activity | Our PHN is currently implementing the state-wide strategy for end-of-life care (EOLC) and the Greater Choice for At Home Palliative Care (GCfAHPC) in our region through a number of key strategies (outlined below). These are supported by our Palliative Care Interagency Steering Committees which include key community partners with links to existing relevant advisory structures including Clinical Councils.<br><br>Palliative care portfolio manager and project officer positions (total 2.4FTE for 2020/2021 FY), have been appointed across the PHN region, based in the Central Queensland, Wide Bay and Sunshine Coast areas, with senior management oversight of these positions. The positions work collectively to plan and implement the |

| | |
|---|---|
| | key strategies outlined below to ensure consistency across the region and share knowledge and expertise. They have commenced interagency steering committees in each of the three areas and have agreed Terms of Reference and an area level plan with each committee. The team also works closely with the national evaluator, Deloitte, provided by the Department of Health to inform the Key Performance Indicators (KPIs) and the provision of data to inform the national evaluation of the measure.<br><br>As part of our commissioning approach, the Central Queensland, Wide Bay and Sunshine Coast PHN (CQWBSCPHN) has defined where we **procure** health services, **partner** with other agencies to implement health system solutions, and where our staff **provide** health system support services (e.g. general practice support, allied health engagement, education, digital health leadership).<br><br>**Objectives**<br><br>**AREA 1: Workforce Capacity and Coordination**<br><br>Objectives:<br>1. Improved healthcare providers' knowledge, skills, confidence and attitude concerning EOLC by end of June 2021<br>2. Increased use of palliative care resources (PHN Pall webpage, PallConsult) and referral pathways (HPWs) by healthcare providers (GPs, pharmacists, nurse practitioners, registered nurses, allied health, residential aged care facility (RACF) staff) by end of June 2021<br>3. Increased numbers of Advance Care Plan (ACP) documents uploaded to The Viewer and My Health Record by end of June 2021<br>4. Increased linkages between primary health care, specialists and palliative care providers by end of June 2021<br>5. Reports of health provider, carer and family satisfaction with community and at home EOLC by end of June 2021<br><br>**AREA 2: Community Capacity and Death Literacy**<br><br>Objectives (to be confirmed and refined in further project plans around specific activity):<br>1. Improved knowledge, skills, confidence and attitude concerning EOLC of families and community providers<br>2. Increased patient/carer awareness of palliative care options (including ACP) and choices<br>3. Reports of carer and family satisfaction with community and at home EOLC by end of June 2021 |

| | |
|---|---|
| | **Key activities for this project/portfolio are:**<br>• Maintenance and updating of PHN Pall Care page on PHN website *(provide)*<br>• Delivery of education webinars to GPs (1 in each area) *(provide and partner)*<br>• Delivery of education dinner to GPs (1 in each area) *(provide and partner)*<br>• Delivery of education event to RACFS (1 in each area) *(provide and partner)*<br>• Delivery of Program of Experience in the Palliative Approach (PEPA) training package to 15 GPs (sponsorship agreement with PEPA) *(procure)*<br>• Continuation and facilitation of the three interagency steering committees (ISCs) *(provide)*<br>• Activities under Compassionate Communities – activities TBD *(partner, procure)* |
| Rationale/Aim of the activity | Investing in quality EOLC is recognised as an important component of quality patient-centred care and ensuring the individual's wishes and values are known and adhered too. Supporting safe, quality palliative care at home and EOLC systems and services in primary health care and community care may also reduce the burden of unnecessary transfers to hospitals and/or reduce costs and poor outcomes associated with avoidable/unwanted interventions.<br>The aims of this PHN Palliative Care Portfolio are:<br>1. to build capacity within the generalist workforce to provide quality EOLC through the provision of clinical resources, referral pathways and EOLC educational events<br>2. to improve coordination and integration of palliative care across primary, secondary, tertiary and community health services and to support equitable access to home-based care for those who choose it<br>3. to build community capacity in EOLC and improve the death literacy of individuals and their families. |
| Strategic Alignment | This project sits under the PHN's health portfolio: Palliative Care.<br>The project contributes to the PHN's strategic objectives 'Healthier Communities' by supporting primary healthcare providers and building capacity of the workforce (RACFs, GPs and pharmacy), 'Strong Partnerships' through working collaboratively with the peak bodies and community organisations to achieve improved health outcomes for palliative care patients and their families, and 'Improve Sustainability' by building the local capacity of the workforce in areas where service gaps have been identified.<br>This project aligns with the Health Needs Assessment. The PHN catchment has high proportions of elderly people. Population projections show that growth rates in the over 65 age group are greater in the PHN region compared to Queensland. By 2021, the PHN population aged 65 and over will be 20.8% compared to |

| | |
|---|---|
| | Queensland 16.2% (p. 14). With this population growth an increasing number of support services and systems to support older people to continue to live in their homes will be required.<br><br>The outcomes from this project will contribute to PHN indicators including:<br>• Health system improvement and innovation (P2)<br>• Support provided to general practices and other health care providers (P4)<br>• PHN activities address prioritised needs (P1) |
| Scalability | Through a monitoring and evaluation process and consulting with key stakeholder, we can assess the effectiveness of the strategies throughout the life of the project. We can identify key barriers and enablers to scaling up and consider the potential reach, adoption and impact of any identified initiatives. These would need to be consistent with national and state policy directions. |
| Target Population | • Local Hospital and Health Service (HHS) specialists, community service providers from the NGO sector, private sector, GPs, nurses, Queensland Ambulance Services and RACFs.<br>• Community social networks – we will partner with the HHS and other key community networks/organisations (e.g. to build Compassionate Communities networks).<br>• Peak bodies in the palliative care space.<br>• Palliative care education providers. |
| Coverage | Our PHN region has an estimated resident population of 842,057 persons, with an average annual growth rate of 1.5 percent over the past five years. Aboriginal and Torres Strait Islander Australians numbered 29,567 or 3.5 percent of the region's population. This percentage is slightly below the state figure of 4 percent. Within the region, Woorabinda had the largest percentage of Aboriginal and Torres Strait Islander people at 94.4 percent.<br><br>Implications for service delivery:<br><br>Currently, there are shortfalls in in-home care, community care, residential aged care and palliative care services across the region, especially in the coastal communities. These shortfalls are expected to increase as the region's population ages and more people move to the coast to retire. Future investments in aged care services and facilities will need to be capable of adequately addressing the changing service needs of older residents throughout the region. |

<table>
<tr><td>Anticipated Outcomes</td><td>
<ul>
<li>Cross-sectoral collaboration will result in increased linkages and improved communications between primary health care providers, specialists and palliative care providers.</li>
<li>Improvement in local clinicians' skills, confidence, knowledge and attitude toward palliative care.</li>
<li>Improved death literacy within the community.</li>
</ul>
</td></tr>
<tr><td>Measuring outcomes</td><td>
Some anticipated outcomes include:
<table>
<tr><th>KPI / Indicator</th><th>Suggested Measures</th><th>Objective</th></tr>
<tr><td><ul><li>Target number of health providers who have attended and completed education (PEPA, on-line modules etc.)</li></ul></td><td>Outputs:<ul><li>number and type of education sessions held</li><li>number of participants attending (reach, stratified by area and profession)</li><li>number of GPs enrolling and completing PEPAs course (stratified by area)</li></ul></td><td>1</td></tr>
<tr><td><ul><li>Perceived (self-reported) changes in skills, confidence, knowledge and attitude in health providers (RACF staff, GPs, pharmacists and allied health professionals)</li></ul></td><td>Outputs:<ul><li>number and type of education sessions held</li><li>number of participants attending (reach)</li></ul>Outcomes:<ul><li>Evaluation forms at each education session (webinars, GP/pharmacy event, RACF event) that measure changes in learning/skill/confidence etc.</li><li>PEPAs placement course – learning outcome, follow up/application into practice</li></ul></td><td>1, 2</td></tr>
<tr><td><ul><li>More healthcare professionals are aware of and use available resources to inform their EOLC and practice</li></ul></td><td><ul><li>Educational event/s attendance data, also include question about awareness of resources etc.</li><li>Number of GPs enrolled/completed PEPAs package</li><li>PHN website metrics (Pall Care page)</li></ul></td><td>2</td></tr>
</table>
</td></tr>
</table>

| | | | |
|---|---|---|---|
| | | • Office ACP upload reports<br>• Evidence of referral pathways used:<br>- Increased number of HealthPathways viewed (monthly reports on page views) | |
| | • % increase or number of completed uploaded ACPs (AHDs/EOPAs/SoCs) into The Viewer | **OACP/Viewer data:**<br>• Number of ACP documentation sent to OACP for The Viewer<br>• Number of completed documents uploaded to The Viewer (includes quality check and completed/accurate). | **3** |
| | • Improved linkages or improved communications between PHC, specialists and palliative care providers | **Outputs:**<br>• ISC meetings, attendance at HHS EOLC meetings, opportunistic meetings/collaborations, e.g. specialists in Central Queensland<br><br>**Outcomes:**<br>• VicHealth – Partnership Tool (pre and post)<br>• Include a question on webinar/education feedback surveys to capture networking and linkages outcomes | **4** |
| | • Good news story or other evidence demonstrating provider, carer and family experiences with community and at home EOLC | • Good news stories from ISC or GPs etc. – anecdotal evidence | **5** |
| Indigenous Specific | Aboriginal and Torres Strait Islander care will be integral to the work undertaken with the interagency steering committee groups. Palliative care positions will work closely with key Aboriginal and Torres Strait Islander organisations, GP practices and local community to understand the palliative and EOLC cultural needs of Aboriginal and Torres Strait Islander peoples. | | |

<table>
<tr><td></td><td>Evidence-based resources and information will be sourced through palliative care peak bodies including ‘CareSearch Palliative Care Knowledge Network’ and ‘HealthInfoNet to support health providers providing care for patients, family and community.<br><br>Local issues and opportunities will be discussed through the Palliative Care Interagency Steering Committees, Clinical Councils and Community Advisory Councils to develop sustainable improvements in the quality of EOLC.</td></tr>
<tr><td>Collaboration/Communication</td><td>The PHN has well-established links into the local community and health provider networks. Regular forums currently convened by the PHN would be a key source of EOLC-specific input to improving service delivery in this area.<br><br>In each area (Central Queensland, Wide Bay and Sunshine Coast) ISCs will work in partnership with EOLC providers to develop sustainable models of care. Members for the committees have been selected variously through an expression-of-interest process, local discussions with the HHSs, and direct approaches.<br><br>Members are expected to contribute to the long-term vision of:<ul><li>Scoping the gaps that relate to the key priority areas to improve and increase at home palliative care services.</li><li>Support the current work of the HHS and collecting EOLC-specific community and consumer input to strengthen the model within the region.</li><li>Identifying service and data development opportunities to support a more integrated model of patient-centred care.</li></ul>The Palliative Care Manager and Project Officers provide outcome reports to the Clinical Councils in each area and more detailed reporting to the PHN. Members of the ISCs provide feedback to their respective organisations.</td></tr>
<tr><td>Activity milestone details/ Duration</td><td>Provide the anticipated activity start and completion dates (including the planning and procurement cycle):<br><br>Activity start date: 01/09/2020<br>Activity end date: 30/06/2021<br><br><table><tr><th>Milestones (updated)</th><th>Start</th><th>Finish</th></tr><tr><td>Collaboration with key stakeholders in the palliative care space to scope potential</td><td>September 2020</td><td>Ongoing</td></tr></table></td></tr>
</table>

| | | | | |
|---|---|---|---|---|
| | opportunities for joint wok (including local HHSs, PEPA, PallConsult, OACP, ELDAC etc.) | | | |
| | Palliative care ISCs recommence on a monthly basis to share palliative care needs and opportunities and to progress local initiatives around Compassionate Communities. | October 2020 | June 2021 | |
| | Palliative care local service information webinars for local clinicians.<br>• Central Queensland<br>• Wide Bay<br>• Sunshine Coast | September 2020<br><br>September 2020<br>October 2020<br>November 2020 | November 2020 | |
| | Partner with PEPA to deliver accessible training opportunities to general practitioners in our region<br>• Commissioning process<br>• Implementation of contracted activity | September 2020<br><br>October 2020<br>February 2021 | June 2021<br><br>December 2020<br>June 2021 | |
| | Linkage with key consumer and community groups across the region and supportive work commenced with Compassionate Communities Network.<br>• Commissioning process<br>• Implementation of contracted activity | July 2019<br><br>December 2020<br>March 2021 | June 2020<br><br>February 2021<br>June 2021 | |
| | Work collaboratively with national evaluator, Deloitte. | September 2020 | Ongoing | |
| | Partnering with peak bodies to source education and training for clinical workforce relevant to local identified need.<br>Face-to-face education:<br>• For RACFS<br>• For Central Queensland clinicians<br>• For Wide Bay clinicians | September 2020<br><br>February 2021<br>March 2021<br>April 2021 | June 2021 | |

<table>
<tr><td></td><td>
<table>
<tr><td>• For Sunshine Coast clinicians</td><td>May 2021</td><td></td></tr>
<tr><td>Program final report and documentation of lessons learnt.</td><td>June 2021</td><td>September 2021</td></tr>
</table>
Other activities as identified through the Palliative Care ISCs.
</td></tr>
<tr><td>Risk Management</td><td>There are some risks associated with the Greater Choice for at Home Palliative Care measure. These include:<br>• Service provider perception of role possibly duplicating existing services which may make engaging with new or non-traditional stakeholders difficult;<br>• Service providers' priorities may be to extend funding of current palliative care direct service delivery not system coordination;<br>• Data sharing agreements and confidentiality challenges with corporate or non-government providers;<br>• Vast geographical area and rural workforce capacity issues, with recruitment and retention challenges in Wide Bay and Central Queensland;<br>• Capacity of the sector to participate in activity (ISC, education, etc.) due to demands on time related to preparedness and potential implication related to COVID.<br>Risk mitigation strategies employed by the PHN will include:<br>• Engaging and consulting early with HHS and current non-government sector to get 'buy in' and reduce risk of duplication;<br>• Leveraging the progress in telehealth capability and acceptability;<br>• In the first instance, concentrating on improving the sharing of de-identified data for high-level indicators;<br>• Professional and adaptable recruitment to the Palliative Care Manager and Project Officer positions in the region;<br>• Upskill general practice workforce to confidently manage EOLC;<br>• Keeping up-to-date with the local COVID situation and allowing for flexibility in planning activity, including various modes for education and deliverables in activity contract allowing for flexibility around COVID-related impacts.</td></tr>
<tr><td>Commissioning method and approach to market</td><td>There are two planned pieces of commissioning with this funding in the 2020-2021 financial year:</td></tr>
</table>

| | |
|---|---|
| | • For commissioning skill-development in the palliative approach locally, a direct approach to the PEPA program was used as this already exists to enhance the capacity of health professionals to deliver a palliative care approach through facilitating clinical placements in specialist palliative care services or through interactive workshops.<br>• The approach to market for work around Compassionate Communities is yet to be determined and will be done so collaboratively with ISC members in each of our three HHS areas (CQ, WB, SC). |