Palliative Medication Proficiency Education

Country South Australia PHN

Project was completed at Midpoint (2024) as part of a wider PHN effort to improve palliative care access and coordination

Overview and objectives of the Project

CSAPHN developed a free online education course focused on palliative care medication, specifically addressing syringe driver use and opioid prescribing.

This course **supported the ongoing continuing professional development** of general practitioners and primary health workers across Country South Australia.

It is widely recognised that competence and confidence in syringe driver use, and palliative opioid prescribing **are areas of need** within the primary health workforce.

Several factors contribute to this, including a lack of available training and financial and time constraints which impede access to training and best practice education.

How it was implemented

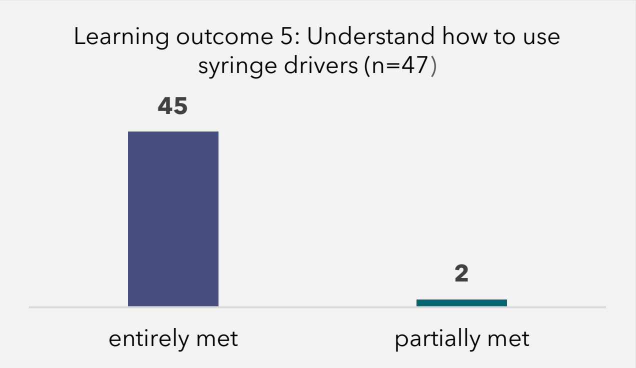
A free two-hour Online Program suitable for GPs, palliative care nurse practitioners, aged care, clinical staff and other interested health professionals.

Program Content includes:

- Planning for end-of-life care in the home setting.
- Identifying the terminal phase of life.
- Initiating subcutaneous medications.
- Practical information for starting a subcutaneous infusion device (syringe driver).
- Steps to take after death occurs at home.

Impact and Outcomes

All **learning outcomes** were either **partially or entirely met** as indicated by participants.


Learning outcome 5: Understand how to use syringe drivers (n=47)

One of the benefits of using a syringe driver is that multiple medications can be combined and administered concurrently over a 24-hour period to help to maintain patient comfort. A workforce with **greater confidence and competence in using syringe drivers,** means more individuals in the community are able to **access palliative care at home** and have their preferences for end-of-life met.

98%

of participants believed that learning outcome of "**recognising signs** that indicate when a patient is approaching the terminal phase of life" was **entirely met**

96%

Of participants **understand how to use syringe drivers** as a result of the course

87%

of participants are extremely likely or very likely **to recommend the course**

*Based on course evaluation data made available by Country SAPHN for period 1 May to 31 July 2024

Palliative Care Champion project in general practice

Western Australia Primary Health Alliance (PNPHN, PSPHN, CWAPHN)

Project is ongoing as part of a wider PHN effort to improve palliative care access and coordination

Overview and objectives of the Project

The Palliative Care Champion project aims **to build GP and general practice capacity and capability to implement a consistent approach to advance care planning (ACP)** as part of routine health assessments for older people and those with complex chronic disease.

The project aims to:

- **Improve awareness and access to palliative care at home** and support end-of-life care systems and services in primary 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 support continuous improvement** of services across sectors.
- **Promote end of life choice** through the proactive promotion of ACP.
- **Optimise MBS item reimbursement** to support ACP and palliative care provision.

How it was implemented

In 2023/24, a **pilot** was undertaken to test this project with **one general practice in each Western Australian PHN region.**

3 General Practices
(1 in each PHN)

24 GPs

11 Practice Nurses

Each site completed a series of **baseline audits** which include:

- ACP and Palliative Care Organisational Audit.
- Learning Needs Analysis Survey (for GPs and Practice Nurses).
- After Death Audits.

The pilot has shown great results and a **further 9 GP practices** will be provided with a small grant to support the role of Palliative Care Champion in FY 2024/25.

Impact and Outcomes of the pilot

Activities and resources provided for General Practices

Dashboard developed to measure key data points related to routine health assessment eligibility and uptake.

Fact Sheet on Planned Palliative Care MBS Items was developed and provided to each practice.

Training and resource kit
- Developed a script for practice nurses – Introducing ACP in general practice.
- Monthly Community of Practice meetings for palliative care champions.

ACP consumer resources including CALD resources

Influencing care provided to
3,519 older Australians
supported by the three pilot sites.

Impacting the care of 1,030 patients with complex needs and potentially unmet palliative care needs who might have otherwise not received palliative care options/ information.

Built relationships with 35 clinical staff across the three sites as well as their support team within each practice who can positively impact patient care.

Assist these practices **to build capacity and capability** in the use of Best Practice software.

Breathlessness Intervention Service (ABIS)

Australian Capital Territory Primary Health Network (Capital Health Network)

Project was completed at Midpoint (2024) as part of a wider PHN effort to improve palliative care access and coordination in the ACT

Overview and objectives of the Project

Chronic breathlessness due to life threatening illness is a **frequent reason for Emergency Department visits** and hospital admissions. Growing research supports the use of symptom-based care to lessen effects of breathlessness. Symptom-based care can:

- reduce impacts of breathlessness
- improve quality of life
- assist families/carers
- potentially **reduce hospital admissions**

CHN worked in collaboration with multiple partners, consumers and clinicians to co-design and develop a pilot of a home Breathlessness Intervention Service.

How it was implemented

ABIS was a 12-month pilot co-designed with consumers and clinicians funded by ACT PHN. Implementation of ABIS as a GP quality improvement project commenced in March 2023, and ended in December 2024. The program offers GP referrals to **physiotherapist and nurse-delivered home visits to patients** suffering persistent breathlessness due to chronic disease.

- Patients were eligible if they had a score ≥2 on a scale assessing degree of baseline functional disability due to feeling breathless (mMRC).
- **Referrals** are invited from general practice and respiratory services.
- Interventions are **non-pharmacological** and address the **'breathing, thinking and functioning'** components of breathlessness.
- Interventions aimed at both the **patient and carer.**

Partners leveraged for the project

- Southside Physio (pilot delivery)
- University of Technology Sydney (pilot evaluators)
- ACT Specialist Palliative Care
- GPs (16 practices)

PHN Population snapshot

22.5% - the ACT has the highest rate of palliative clients nationwide (per 10,000)

8.4% - Average annual increase in hospitalisations for palliative care in the ACT (2014-15 to 2018-19)

Breathlessness Intervention Service (ABIS)

Australian Capital Territory Primary Health Network (Capital Health Network)

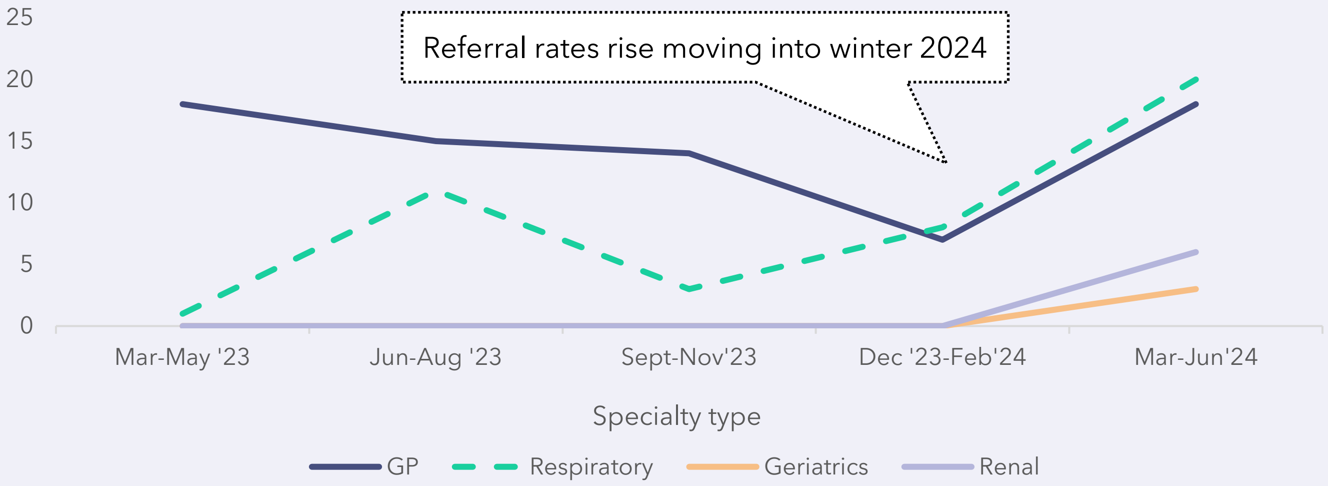
Impact and Outcomes

134 **patients referred to ABIS** (to July 2024) who would have otherwise continued without learning to self-manage their breathlessness.

All 59 patients who completed the initial trial **achieved improvements on at least one outcome**, such as mastering breathlessness and reducing breathlessness severity.

75% **of carers** who participated in the workshops during the pilot **reported improvements in confidence in caring** for the patient. Patients and carers **reported mental benefits** because of training. Very few had received support for management of breathlessness.

On 44 occasions 27 **patients avoided calling an ambulance** by self-managing breathlessness using the techniques they learned through ABIS (based on self-report phone follow- up conversations with patients of **115 patients** after completing the program).



Number of patients referred per month, by specialty (n=124)

Referral rates rise moving into winter 2024

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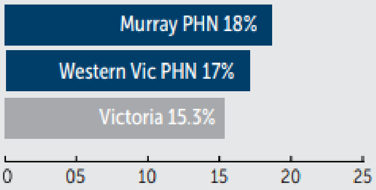
[1] www.chnact.org.au/for-consumers/trials

Palliative Care Quality Improvement project

Regional Victorian PHNs (Murray, Gippsland and Western Victoria)

Project is ongoing as part of a wider PHN effort to improve palliative care access and coordination

PHN Fast Facts



The Murray PHN region has 18.6% of its population aged over 65 years, similar to Western VIC PHN (17%), (VIC 15.3%), with Gippsland PHN having a bigger prevalence, with 1 in every 4 adults[23, 31, 32, 33]

In 2019-20, there was a 24% increase in preventable hospital admissions and Emergency Department presentations due to dementia, in the Murray PHN region[32]

Dementia remains the second most common cause of death among all people in the Gippsland and Murray PHN regions and still highly prevalent in the Grampians-Wimmera regions in Western Victoria

Source: Palliative Care Quality Improvement Toolkit for general practices in Victoria, by regional Victorian PHNs

Overview and objectives of the project

The project involves a collaboration between the three regional Victorian PHNs who are piloting a Palliative Care Quality Improvement Toolkit in general practices to **support GPs** in improving timely identification, response and management of patients living with life-limiting illnesses.

The pilot sought to address known challenges in the catchments related to:

1. Low identification of patients living with life limiting illness.
2. High rate of preventable hospital admissions.
3. Need for models of care to address clinical deterioration of patients.
4. Need for upskilling of workforce required in areas such as Advanced Care Planning, Palliative and End of Life care.

How it was implemented

18 General Practices across 3 PHNs involved in pilot

Phase 1 (complete)
QI toolkit development

»

Phase 2 (complete)
12-month pilot

»

Phase 3 (started Sept '24)
Internal evaluation and reporting

Check-ins
with PHN project staff
- Orientation
- Monthly meetings

3 x quality improvement activities to be undertaken in each practice

6 x PEPA online modules to be completed by each practice

Completed **After – Death Audit** and **Death Literacy Index** at end of project

Palliative Care Quality Improvement project

Regional Victorian PHNs (Murray, Gippsland and Western Victoria)

Implementation activities

Established **clinical meetings** to discuss palliative care patient journeys

New internal mechanisms to identify patients who would benefit from palliative care discussions

Reviewing resources / referral pathways

Introduced a focus on **75+ Health assessments**

Upskilling workforce on palliative care knowledge

Increased **Advanced Care Planning**

Utilising online systems for when patient is being seen by another GP in residential aged care

Impact and Outcomes

The QI Toolkit is being well received and implemented in pilot sites

92%

of surveyed practitioners agree that the project has **increased Advanced Care Planning discussions**

100%

of GP staff part of the project who also attended associated Advance Care Planning workshops would **recommend it to a colleague**

General practice staff members part of the project were invited to attend Advance Care Planning (ACP) workshops. There is evidence that those that attended have increased knowledge and skills of ACP.

Percentage of attendees confident in
'Understanding the law regarding ACP'

Percentage of attendees confident in
'Understanding the patient's right to limit or refuse treatment'

Percentage of attendees confident in
'Initiating an ACP discussion'

Percentage of attendees confident in
'Completing ACP documentation'

Percentage of attendees confident in
'Discussing the role of the medical treatment decision maker'

Percentage of attendees confident in
'Locating resources to support ACP'

Advance Care Planning (ACP) in Community

Central Queensland, Wide Bay and Sunshine Coast PHN

CCQPHN Fast Facts (as at June 2019)

877K residents **1.1m** projected by 2036

Project is ongoing as part of a wider PHN effort to improve palliative care access and coordination

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21.7%
Aged 65 and above

3.6%
Aboriginal and/or Torres Strait Islanders

5.4%
Born in non-English speaking countries

66.9%
living outside of metropolitan areas

CCQPHN scoped the level of existing awareness

> “70% of respondents stated they had thought about their future health care.
>
> Respondents felt the most important times to complete an ACP was if:
> - they were diagnosed with a terminal illness
> - they became too old and frail
> - they were diagnosed with dementia”

Activity objectives

CCQPHN's ACP project **aims to raise awareness, understanding and confidence in ACP in the community.** It is delivered in partnership with the Queensland Office of Advance Care Planning (OACP) and includes:

- ❖ a commitment to improving ACP literacy
- ❖ earlier engagement with ACP
- ❖ increasing accessibility to key resources

How it was implemented

- ❖ **Train-the-trainer** education programs for volunteer community members, to ensure a sustainable program.
- ❖ The provision **of evidence-based resources to local clinicians** to build awareness.
- ❖ Sharing **standardised documentation,** and.
- ❖ **Establishing community champions** who facilitate community discussions, promote ACP, and assist with navigation of resources and support.

The role of a volunteer ACP community Champion

Define: and facilitate formal and informal community ACP discussions.

Promote: the advantages of ACP to the local community.

Direct: Assist community members in accessing support and resources. Be a source of information about further support.

Connect: community members to the Statewide Office of Advanced Care Planning and Queensland ACP documents.

Advance Care Planning (ACP) in Community

Central Queensland, Wide Bay and Sunshine Coast PHN

Impact and Outcomes

612 **total participants** over **64 hours of ACP education**

475 **Community members** accessed **42 hours of ACP education**

95 **GPs and health clinicians** accessed **7 hours of ACP education**

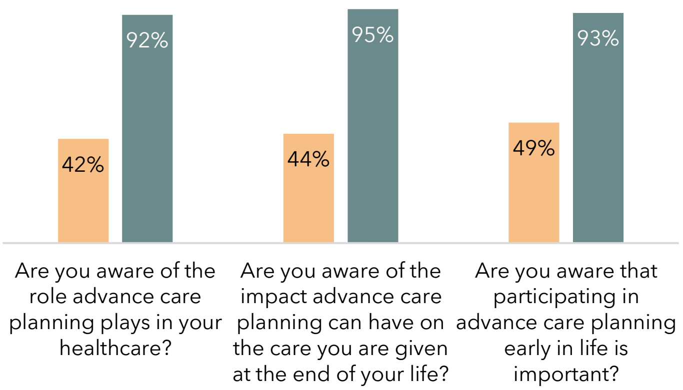
41 **ACP champions** accessed **15 hours of ACP education**

80% of respondents reported **improved confidence and awareness**

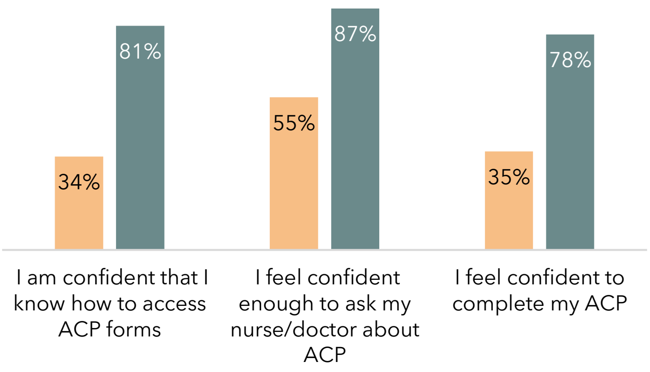
Survey results

🟧 Pre % 🟩 Post %

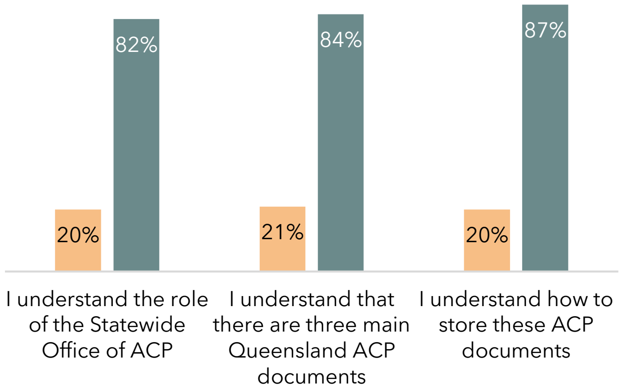
Awareness of ACP



Confidence accessing and completing an ACP



Understanding of ACP documents



Increased and continuing conversations around ACP has the potential to:

- ✓ **Empower and prepare community members** by helping individuals to understand the importance of planning for future health care decisions
- ✓ Improve access to **right care, at right time and right place**
- ✓ Has **potential to reduce unnecessary hospitalisations**
- ✓ Lead to **more efficient utilisation of healthcare resources**
- ✓ Enhance formal and informal community support

Palliative Care Access to core Medicines (PCAM)

Metropolitan Melbourne PHNs (EMPHN, NWMPHN & SEMPHN)

Project is ongoing as part of a wider PHN effort to improve palliative care access and coordination

Overview and objectives of the project

The PCAM project aims to support palliative care in the community with a focus on end-of-life care through **enhanced planning and access to essential medicines** to aid people who wish to die at home.

Partnering with the Pharmaceutical Society of Australia (PSA), **a Core Medicine List (CML)** was established in consultation with local palliative care providers and **an interactive map of pharmacies was developed** of pharmacies stocking CML medications.

The project aims to:

- ❖ Increase the number of **community pharmacies** stocking CML medicines
- ❖ **Increase awareness o**f anticipatory prescribing
- ❖ **Enhance collaboration** between GPs and community pharmacists
- ❖ **Improve timely access** to palliative care medicines for patients

How it was implemented

The PCAM Project established the CML in 2022. A broad range of communication and engagement activities were conducted within the PHNs and PSA networks to create awareness and encourage community pharmacies to stock the CML including:

- ❖ **Letter of intent for provision of PCAM project** to increase awareness and encourage pharmacies to commit to stocking CML. Pharmacies completed the Letter of Intent to signal their participation in the project.

- ❖ **Engagement with pharmacy banner groups** to cascade information to their member pharmacies and encourage participation

The PCAM Online hub: An online repository for pharmacists and health professionals on the PSA website with relevant resources including:

- An embedded map of participating pharmacies
- Frequently asked Questions
- Links to recordings and webinars
- A list of resources regarding palliative care
- Letter of Intent for Pharmacists

Impact and Outcomes

305 Participating pharmacies committed to stocking CML. All can be found on the interactive map.

>100% Rise in number of participating pharmacies from Nov '23-Oct '24

Increased and continuing commitments from pharmacies to stock CML:

- ✓ **Enhances community access** to palliative care medicines
- ✓ Improves access to **right care, at right time and right place**
- ✓ Has potential to **reduce unnecessary hospitalisations**

Upskilling the interpreter workforce in palliative care settings

Brisbane South Primary Health Network

Project was completed at Midpoint (2024) as part of a wider PHN effort to improve palliative care access and coordination

Overview of the project

This project aimed to provide professional development training to **upskill practicing professional interpreters working in, or intending to work in palliative care settings.**

BSPHN worked with 2M Language Services to conduct **training and awareness for language interpreters** on how to access ACP and palliative care information, services, and communicating these to CALD communities.

Objectives of the project

- Improved outcomes for **CALD consumers of palliative care.**
- **Improved knowledge** and understanding of palliative care.
- **Upskilling interpreters** to feel better equipped with palliative care conversations.
- **Creating resources for interpreters** to assist with palliative care conversations
- Raise awareness of the role of interpreters.
- Attract interest amongst interpreters to work in palliative care settings.

How it was implemented

Face-to-face training

Onsite visits to palliative care settings

Discussions guided by a facilitator

Interpreters from regional Queensland and interstate were invited to attend hybrid components of the training. A video-library of resources was created for interpreters who could not attend in person.

Project partnerships

2M Language Services

The most significant change for interpreters has been reported as understanding palliative care:

"Better, understanding [of the demands] of both palliative care and self-care "*

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*information sourced from PHN and 2M Final Project Report: Upskilling the Interpreter Workforce in Palliative Care Settings

Upskilling the interpreter workforce in palliative care settings

Brisbane South Primary Health Network

Impact and Outcomes

90

Attendees
across events
(FY23/24)

92%

increase in understanding of palliative care principles and its aims

87%

increase in confidence interpreting palliative care settings
*see short term outcomes

Short term outcomes

- **Improved knowledge** of palliative care in interpreter workforce.
- **Increased comfort and confidence** translating palliative care, medical and end-of-life discussions.
- Enhanced **ability to aid health consumers** with language barriers to navigate palliative care and end-of-life needs.
- Improved overall interpreting skills in palliative care conversations to **better support CALD health consumers** in meeting their care preferences and needs.

Medium Term Outcomes

- **Increased number of interpreters** willing and able to participate in teams around palliative care.
- **Improved quality of palliative care discussions** between consumers, loved ones and the multidisciplinary team.
- Potential to increase the number of interpreters willing to work in palliative care setting.

Long Term Outcomes

- **Improve cultural safety** of palliative care provided by the multidisciplinary team.
- **Improve the quality of palliative care received** by CALD health consumer.
- Potential to **increase the quality and volume of information** about palliative care to CALD community members.
- Potential to **increase the number of CALD community members having access** to palliative care.

*information sourced from PHN and 2M Final Project Report: Upskilling the Interpreter Workforce in Palliative Care Settings

Living and dying well for people with disability: palliative and end of life care knowledge framework

Brisbane North PHN

Project is ongoing as part of a wider PHN effort to improve palliative care access and coordination

Overview and objectives

The framework is designed to **ensure people with disabilities receive dignified and appropriate palliative and end-of-life care.**

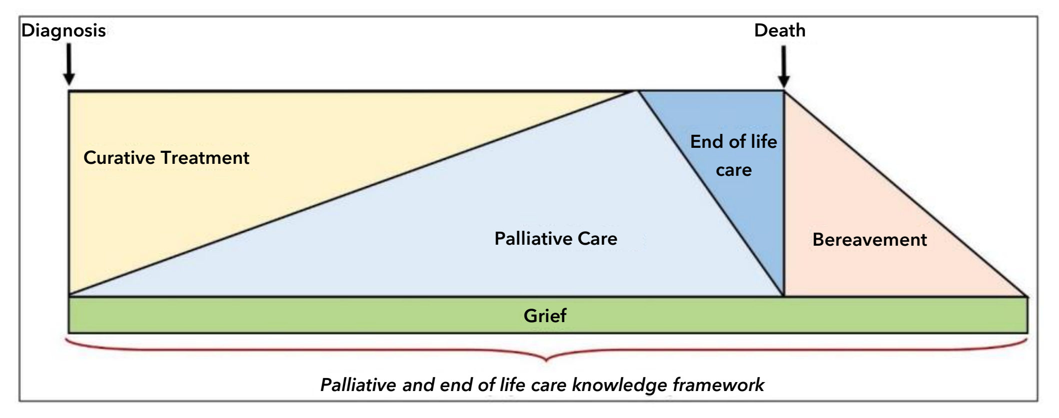
The project aims to:

- Create a **comprehensive knowledge framework** to guide and help care providers who support people of any age with any disability and life-limiting conditions.
- Describe the **knowledge care providers need** when they support people with disability though their palliative and end-of-life journey.
- **Share education and training resources** for people working in disability and health.

Intended outcomes

- **Enhance the knowledge and skills** of disability service providers and care staff to deliver high-quality palliative and end-of-life care.
- **Improve equitable access to palliative care** for people with disabilities by implementing a co-designed action plan.
- **Support communication** between healthcare providers, individuals with disabilities, and their families to ensure care preferences are understood and respected.
- **Promote dignity and choice** by providing tailored care to individuals with disabilities that aligns with their wishes and needs.
- **Build a community network** that shares resources, experiences, and best practices in palliative care for people with disabilities.

Figure 1: Life period covered by the framework



The framework was developed in consultation with:

- People with disabilities and their carers
- Disability and palliative care organisations
- Disability service providers
- Disability accommodation providers
- Specialist palliative care services
- Community palliative care services
- Services that support people with disabilities in hospitals and health
- Aboriginal and Torres Strait Islander services
- General practitioners
- Government departments
- Academics and researchers

Living and dying well for people with disability: palliative and end of life care knowledge framework

Brisbane North PHN

The framework consists of:

1. **13 identified domains** of palliative care knowledge (e.g. collaboration, recognizing the need for palliative care).

2. Each domain sits under **one of 2 levels.** Some domains includes knowledge that applies when caring for an individual (direct care level), while others apply to the management of organisation and services (service level). 'Collaboration' is a domain that sits across both levels.

3. Each domain has an identified **lead or co-lead sector**, who would take responsibility for coordination of the domain. Leads can include the disability sector or the health sector.

4. Underpinning the framework is the **sector and policy level** which represents the input from authorities, legislation, government policy, programs, and strategies. It is included in the framework to acknowledge that practice is influenced by, and will influence, sector and policy level

Potential community impact and outcomes

Increased access to services for people with disabilities, ensuring they receive the same level of care as others.

Improved quality of care through enhanced skills and knowledge to ensure that individuals with disabilities receive care that meets their specific needs and preferences and leads to better outcomes.

Community awareness to increase awareness about the importance of palliative care for people with disabilities can lead to broader community support and understanding.

Better coordination of services to encourage collaboration between service providers ensures a more integrated and coordinated approach to care, and efficient use of resources helps to maximise the impact of care provided.

Community-based care ensuring individuals can receive support in a familiar and comfortable environment.

Strengthened support networks supported families and caregivers by providing resources and support for families and caregivers, as well as the general community fosters a more inclusive and supportive environment.