



Primary Health Networks (PHNs) funded to implement the Greater Choice for At Home Palliative Care (GCfAHPC) measure

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FOR FURTHER INFORMATION

If you would like more information on the GCfAHPC measure, please visit the [GCfAHPC measure 'Frequently Asked Questions'](#) page on the Department of Health website or send an [email to the Department of Health - Palliative Care inbox](#) at Palliative.care@health.gov.au.

PHN Name: Murrumbidgee PHN

Project Name: Murrumbidgee at-home palliative care program

The Murrumbidgee at home palliative care program will implement a number of key initiatives across the region to improve integration and the capability of community and service providers to support at-home palliative care.

Initiatives will include:

- Working with local rural communities to adopt the Compassionate Communities Framework including identifying existing caring networks;
- Mapping of roles and responsibilities of partner service providers across the region to improve communication and continuity of care;
- Working with local communities and service providers to improve access to medication particularly in the after-hours period;
- Working with general practices to upskill in advance care planning and implementing the palliative approach, along with the development of HealthPathways; and
- Undertaking a Multidisciplinary Telehealth Trial in 6 small rural communities to support access to primary care and palliative care services, with an additional focus on the after-hours period.

PHN Name: South Western Sydney PHN

Project Name: PEACE of MIND Project (POMP)

SWSPHN is developing an integrated model of end-of-life planning and palliative care delivered in the place of choice for people aged 70 years and over with dementia but intact decision-making capacity. The model will include a focus on earlier diagnosis, early engagement with advance care planning and palliative care education along with elements of public awareness raising, health and death literacy and the building of informal support networks. Objectives of the project include:

- Individuals receiving a dementia diagnosis with intact decision-making capacity will have choice, quality of care and support through early engagement with advance care planning and palliative care and the growth of informal support networks through Compassionate Communities;
- Primary health care providers will have access to an integrated model for palliative care in a person's place of choice that incorporates clear triggers for escalation for dementia and palliative care. This model will be accompanied by supportive tools such as a published HealthPathway with associated localised patient fact sheets, advance care planning documents and decision support tools that assist in recognition of a deteriorating patient;
- The burden on families and carers will be reduced, through early engagement with advance care planning and palliative care and the growth of informal support networks through Compassionate Communities; and
- The community will benefit from increased health literacy through exposure to education on dementia, advance care planning and palliative care and the value gained through early engagement.

PHN Name: Western NSW PHN

Project Name: The SHARE (Shared Health and Advance Care Record for End of life choices) Project: implementing a shared Palliative Approach across Far West and Western NSW

The SHARE (Shared Health and Advance Care Record for End of life choices) project will build on system change achieved through a Decision Assist Linkages project led by Far West Local Health District (FWLHD) Specialist Palliative Care Team (SPCT) in partnership with Residential Aged Care Facilities (RACFs). The Far West Palliative Approach Framework (FWPAF) was developed to build capacity and improve provision of comprehensive, consistent, patient-centred, needs-based, high-quality palliative and end-of-life care (PEoLC) for all, irrespective of diagnosis, care location or care provider.

Stage 1 (April to June 2019) - Western NSW PHN is working to develop the FWPAF into an electronic format (ePAF) for implementation in community and primary health care settings across WNSW PHN, incorporating FWLHD and Western NSW Local Health District (WNSWLHD).

There are two main components to the ePAF:

- development of an online resource centre; and
- development and implantation of a shared care record (Shared Locality Record (SLR)).

Both the resource centre and SLR implementations aim to affect meaningful change within the extended community.

Stage 2 (July 2019 to Jun 2020) - WNSW PHN will recruit two Palliative Approach Linkage Officers (PALOs) to work collaboratively with each LHD SPCT to facilitate implementation of the FWPAF and ePAF in selected 4 pilot sites:

- One General Practice and one MPS in FWLHD; and
- Two RACF in WNSWLHD.

The implementation program in each LHD will allow PALOs and SPCTs to provide focused and localised planning, development, implementation, sustainability and evaluation activities at each site.

PHN Name: Adelaide PHN

Project Name: Enabling Choice for South Australians

Enabling Choice for South Australians (ECSA) is the Adelaide PHNs response to the *Greater Choice for At Home Palliative Care* measure. ECSA aims to build on existing resources and programs to support capacity building and continuous quality improvement (CQI) in the planning and delivery of palliative and end-of-life care.

Adelaide PHN has developed Memorandums of Understanding with six aged care organisation to deliver palliative care quality improvement packages across 21 residential aged care sites. Two Quality Improvement Facilitators will work directly with each organisation to build organisational, workforce, resource and partnership capacity to improve planning and delivery of palliative care and end of life care. An Inter-sectoral Collaboration Group representing key stakeholders and partners will act as a cross industry forum to disseminate and integrate feedback and learnings. The project will commence in mid-November and it is likely a second round of offers to aged care organisations in 2019 will provide further opportunity to expand reach and scope to include community based aged care services.

PHN Name: Brisbane South PHN

Project Name: At Home Palliative Care

The At Home Palliative Care project aims to improve the provision of palliative care and end-of-life services for residents in the Brisbane South PHN region with a focus on greater choice in quality, culturally appropriate, at-home services. Brisbane South PHN seeks to achieve this by improving the at-home care options and integration of care between different care providers within and across sectors relevant to the provision of palliative care services.

The project will address issues impacting the general population and identify specific strategies for CALD and refugee communities to improve access to at home palliative care services for all in the Brisbane South region. Outcomes will include:

- Increased knowledge of the local health system generally and for accessing palliative care services and end-of-life support specifically, for palliative care consumers, carers/families and their wider communities, formal and informal networks;
- Increased skills, confidence and cultural competency of health professionals to deliver comprehensive, evidence base palliative care and end-of-life services;
- Documented care pathways connecting palliative care services between primary, acute and aged care sectors;
- Identification and collection of relevant data to develop an evidence base to support and demonstrate the achievement of change and outcomes;
- Evaluation of and report on findings and lessons learned from the project to guide future initiatives;
- Increased access to culturally appropriate services for palliative patient, their family and carers and their wider community including formal and informal networks; and
- Coordination of local health services.

PHN Name: Central Queensland, Wide Bay, Sunshine Coast PHN

Central Qld, Wide Bay & Sunshine Coast (CQWBSC) PHN is implementing the *Greater Choice for At Home Palliative Care* through six key strategies:

STRATEGY 1: Improve **access** to safe, quality palliative care at home and support EOLC systems and services in primary health care and community care;

STRATEGY 2: Enable the right care, at the right time and in the right place to **reduce unnecessary hospitalisations**;

STRATEGY 3: Generate and use **data** to ensure continuous improvement of services across sectors;

STRATEGY 4: Utilise available **technologies** to provide flexible and responsive care, including care after usual business hours;

STRATEGY 5: Increase **community capacity building** (e.g. Compassionate Communities Network) within our PHN region; and

STRATEGY 6: Increase **workforce development** and capacity.

CQWBSC PHN is working collaboratively with key partners through our Palliative Care Interagency Steering Committees with a focus on the identification of local issues, the implementation of sustainable solutions, increasing death literacy and promoting and fostering strong relationships between service providers, consumers, carers and families.

PHN Name: Gold Coast PHN

The aim is to clearly identify the needs of the local community in relation to palliative care and through co-design with consumers, providers and the broader community to determine the optimal model of palliative care for the Gold Coast supported by a regional implementation plan.

- **Primary Health Palliative Care Project:** provide general practitioners with easy access to localised information for clinical care, ongoing person-centred management, coordination of service providers for a wide range of palliative care conditions through an online one-point interface. General Practitioners (GPs), will be supported with training and education for the management and care coordination of person-centered and home-and-community-based palliative care.
 - *GP Palliative Shared Care* program: Sharing of provision of care between general practitioners and specialist palliative care services with clinical support and guidelines to assist GPs in meeting the needs of their palliative and end of life patients. The shared care program framework will be available to participating GPs via the online Palliative Care Portal. This is inclusive of patients' needs assessment, engaging in case conference with MDT, development of shared care plans which are supported by patient management plan. The program will include effective use of tools and resources such as My Health Records.
- Development of a region wide **Palliative Care Volunteers Network:** supportive communities of volunteers/ befriending schemes, to support the carer in daily tasks, provide a listening ear, or direct support to the person with an illness.
- Implement a **Community Awareness and Education** palliative care initiative to encourage people talk more openly about dying, death and bereavement, and to make plans for the end of life inclusive of Advance Care Plans.
- **RACF Palliative Care Quality Improvement Project:** Establishing a Palliative Care Support Framework for health professionals supporting RACF's in clinical care and coordination of palliative and end of life care patient management. The aim is to ensure all patients at end of life receive high quality care provided by RACF's that encompass the philosophy of palliative care. End of life care champions within the organisations are supported to develop their knowledge, skills and confidence and encouraged to empower staff within the organisations to deliver quality end of life care. This will be achieved by:
 - Developing and implementing residents' advance care plans and end-of-life care coordination, supporting more residents to die in their place of choice;
 - Implementing quality improvement tools and instruments to support clinical care coordination and management plans; and
 - Creating a more sustainable after-hours GP workforce

PHN Name: Country WA PHN

Project Name: Compassionate Communities, Greater Choice for At Home Palliative Care

This project aims to improve access to safe, quality palliative care at home and support end-of-life care systems in Primary Health and in the community. Key elements are:

- Improving the care coordination and clinical pathways across primary, secondary, tertiary and community health services to support at home palliative care; and
- Building community capacity, social capital and empowerment to create supportive environments for individuals around death dying and loss.

With an initial focus on the Great Southern Region of Country WA, the project will be tested for transferability to the WA Kimberly region.

PHN Name: Eastern Melbourne PHN

Project name: Greater Choice for End of Life Care

To achieve better care for people with life limiting conditions and to support those people involved in their care, EMPHN will implement programs to:

- 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;
- use human resources and/or technological approaches to provide care at home, particularly after-hours;
- increase the number of Advance Care Plans being completed in the community;
- 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);
- integrate services that exist in the after-hours period, with a particular focus on GP deputising services;
- focus on ensuring more people are able to die in their place of choice or remain in their home as long as possible; and
- Promote the increased use of Health Pathways Melbourne, which has a comprehensive suite of palliative care pathways, to provide comprehensive clinical decision making tools and referral pathways for GPs.

EMPHN will progress the work of the Eastern Melbourne Primary Health Care Collaborative End of Life Care working group, participate in the Monash Health Chronic Disease Strategy Working Group and establish a similar End of Life Care working group with Better Health North East Melbourne, ensuring coverage across the entire catchment. An Action Research approach will be taken to improve capacity within the catchment to deliver palliative care services to people in their homes.

EMPHN and the EMPHCC EoLC Working Group Collaboratives have established Data Management working groups which will be utilised to support data development activities. 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:

- service mapping information;
- statistical and demographic data;
- increased palliative care provision at home;
- averted emergency presentations and inpatient admissions;
- increased advance care plans completed and registered;
- patient journey understanding and experience; and
- service/hospital presentation data.

PHN Name: North Western Melbourne PHN

Using a multi-phased approach, NWMPHN will build on existing knowledge, resources and relationships as we partner with stakeholders, service providers, consumers and carers. The approach will focus on:

- Workforce capacity building, using existing resources;
- Improving service pathways;
- Consumer, carer and family engagement;
- Data driven quality improvement; and
- Integrated models of care.

We will use NWMPHN's commissioning principles as a framework to develop activities in each of these focus areas. Activity will be structured into phase 1, phase 2 and phase 3, which align with the following stages of the NWMPHN commissioning cycle: 'develop insight', 'plan and deliver', and 'evaluate and improve'. Each of these phases will inform the development, implementation and evaluation of GCfAHPC for NWMPHN.

Develop Insight / Phase 1

Phase 1 will identify the needs of local NWMPHN communities. This will involve collecting and reviewing information and data from various sources. Findings from this phase will be consolidated, mapped against the focus areas, and then prioritised based on need.

Plan and Deliver / Phase 2

Phase 2 will involve implementing prioritised activity based on outcomes of Phase 1.

Evaluate and Improve / Phase 3

Phase 3 will involve monitoring and evaluating the commissioning activity in Phase 2. This will include using a mix method approach (quantitative and qualitative) to evaluate the outcomes achieved and will align where possible with the larger GCfAHPC evaluation.

PHN Name: Primary Health Tasmania

Primary Health Tasmania (PHT) will identify and work with targeted rural communities to design and implement a whole of community approach to palliative care where families, carers, local communities along with health care professional, volunteers, social networks, hospitals, faith groups, local businesses, local organisations and neighbours are skilled, capable and confident to respond to the experiences of death, dying and bereavement.

PHT will:

- **Engage with communities** - utilising a community development approach, understand how communities are best engaged in identifying and addressing end-of-life care needs. Stakeholders include: consumers, carers, local service providers, local government and the community;
- **Improve team-based care and transfers of care** - working with providers to develop local team-based care service models reflecting community needs. Taking a strength-based approach to identify community assets in the local service provider system and community supports. The project will then 'wrap around' this system, appropriate capacity building, governance arrangements and model of care, to strengthen local service system for people in need of end-of-life care; and
- **Apply team-based care tools** - supporting sustainable local service models using evidence-based tools for improved team-based care, further detailed at criterion three.

Aim: The aim of the activity is to improve access to end of life care in rural communities.

The project will be implemented within a compassionate community framework in rural communities and will therefore involve a whole of population approach at a local level.