Australian Government
Department of Health

phn
An Australian Government Initiative

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

WAPHA Country

Approved by the Australian Government Department of Health, May 2018 (Version 2)

Introduction

Overview

WAPHA's strategic priorities include:

- Health Equity and Access
- Person Centred Models of Care
- Integrated and Outcomes Focused Commissioning
- Strong Partnerships
- Primary Care Capability

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.

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.
Description of Activity	**With an initial focus on the Great Southern Region of Country WA,** this activity aims to improve access to safe, quality palliative care at home and support end-of-life care systems and services in primary health and community care. Key elements are: • Improving the care coordination and clinical pathways across primary, secondary, tertiary and community health services to support at home palliative care. • Regionally focused, place based approach to service development that capitalises on the strengths of the WA Primary Health Alliance (WAPHA). By applying the Compassionate Communities (CC) approach to this project we will support communities in recognising the needs of people who are approaching their end of life, bringing together community providers from local government, not for profit organisations and community to support these needs. Providing a community development approach by helping to build social capital through enhancing community networks and building resilience. • Working with communities rather than for them • Identifying and implementing solutions where required • Building on existing skills and knowledge of consumers and clinicians • Creating meaningful partnerships.

	The aim is to improve health and wellbeing at the end of life, noting that a public health approach to end of life care goes further, encouraging communities to develop their own approach to death, dying loss and caring. Responsibilities and duties of the positions includes but not limited to: • Working with key stakeholders within the community in collaboration with the Compassionate Communities Coordinator (CCC) to recognise the consumers that are palliative. • Work with the community palliative providers to maintain and strengthen the quality of services for the most fragile and vulnerable within the palliative scope to normalise the course of their lives. • Work collaboratively as a team to support the development the 13 social changes to the cities key institutions and activities • Support the development of the community partnership and reference group to the Greater Choice for at home Palliative Care; • Map the resources that are available nationally to the Compassionate Communities Palliative measure. • Work collaboratively with the Great Southern DHAC and other community representatives. • Collaborate with the community to have key bodies/ groups work to the City charter. • Coordinate and organise community engagement activities that support evidence based, cost effective service delivery that is sustainable and leads to better health and wellbeing for people with complex chronic conditions at end of life. To enable them to live and experience end of life at their place of choice within their local community. • Implement key engagement strategies that inform to support the planning around the Compassionate Communities (CC) approach. • Work with Palliative service providers towards building on a compassionate community approach to wellness in end of life care. **Implementation** **STAGE 1** The Compassionate Communities Coordinator (CCC), 1.0 full time equivalent (FTE), will coordinate the project and facilitate the uptake of the deliverables of the CC Charter by the City of Albany. The second FTE, the Compassionate Communities Capacity Builder (CCCB), will be responsible for engagement with community and networking with services to inform the CC charter. To achieve this the Staff will engage and collaborate with: • Regional palliative care services provided by WA Country Health Services (WACHS)/ Silver Chain Group (SCG) including Integrated Chronic disease programs as well as community, private and government agencies. • State-wide palliative organisations such as Cancer Network, Palliative Care WA and SCG, and other PHNs. The approach is outlined below:

	1. Compassionate Communities assessment • Assess the community strengths, discomforts and fears • Access resources, including use of Apps and e-learning modules. **2. Focus and commit** • Facilitate formal and public discussions on the concepts within the Charter for Compassion • Support community partners to commit to and sign the Charter. **3. Build** • Develop local action plans focused on palliative areas /toolkit/public agenda • Link the broader regions (including remote) to the CC concept • Disseminate community tool box resources, including exploring linkages with RFDS 'community chests' • Utilise available technologies to provide flexible and responsive care, including care after hours. **4. Evaluate and sustain – fourth quarter to project completion** • Monitor and measure (refer to Charter Website) against agreed outcomes. **STAGE 2** **1. Extend** • Share the information on the evolvement of the project and where required on WAPHA exchange and other mediums • Test whether the CC model framework is transferrable to other regions **Governance** A steering committee will meet monthly then bi-monthly after first quarter and will have membership from the local hospital, WACHS population health, pharmacy, digital health, general practice (GP), Local Government Authority (LGA), hospice, Rural Clinic School, (RCS), St John Ambulance (SJA), SCG, Creative Albany and consumers. This group will provide reports to the Regional Clinical Commissioning Committee(RCCC) and report through the Country PHN Manager to the board and PHN Council within the PHN governance structure The District Health Advisory Council will have input and active involvement. In line with the place-based, community led approach, GAFAHP staff will be line-managed by the PHN Regional Manager In addition a Memorandum of Understanding (MOU) with the key community organisations will guide the partnerships. **Data Development Activities** • Adapt the Advanced Care Planning, using MyHR, to WA. • Generate and use data to ensure continuous improvement of services across sectors.

	• Technological support to integrate palliative care patients into afterhours Primary Health Collaborative. Technological solution to mapping needs and matching with resources.
Rationale/Aim of the Activity	Several meetings and discussions to this pilot model design have informed the workplan. Meetings have been held with Regional Clinical Commissioning Committee (RCCC), WACHS, City of Albany, Rural Clinical School of WA, Albany Hospice, St John Ambulance and Silver Chain Group. There has been community consultation within the Great Southern undertaken by the WA Sustainable Health Review where the Compassionate Communities approach was recommended. Meetings have been undertaken with SJA and supported at an executive level with the plan to review the NSW paramedic model for afterhours symptom management and pain control. To ensure integration with other programs in the scoping and design of the program, discussions were held with relevant organisations to support linkage with: • The Primary Health afterhours collaborative • Aged Care Charter • Health Navigator • Nurse Practitioner program in Katanning • eLearning Medication management for Untrained Health Workforce (in Aged Care settings) • Integrated Chronic Disease Coordination (ICDC) service providers in the Great Southern.
Strategic Alignment	WAPHA's strategic priorities include: • Health Equity and Access • Person Centred Models of Care • Integrated and Outcomes Focused Commissioning • Strong Partnerships • Primary Care Capability. The following priorities from the Needs Assessment Report 2017 (pages 44-50) apply: P1: Orient Primary Health care towards marginalised and disadvantaged people, particularly in communities where there are lower levels of primary care provision.

	P2: Orient primary health care towards vulnerable people supporting primary health care providers to adopt appropriate approaches for targeted groups. P3: Primary care providers work with Aboriginal people and groups to plan and design strategies that address localised priorities. P4: Improve transitions between services by supporting effective care pathways, care coordination and service linkages. P6: Support local communities to be connected to primary care in and out of hours. P7: Build the capacity for patient self-management particularly for patients with co-occurring and multiple morbidities through the support of appropriate primary care providers. P8: Build community awareness of when and where to seek non-urgent health care. P9: Reduce rates of PPHs by working with primary care providers to target specific areas where there are higher than average rates. P10: Promote the effectiveness of digital health technologies to optimise patient care. P11: Invest in services that have demonstrated health outcomes by commissioning to a validated Outcomes Framework in order to demonstrate services are efficient and effective. The GCfAHPC will improve the efficiency and effectiveness of Medical services for patients particularly those at risk of poor health outcomes by: • Working with the key stakeholders within the region, ensuring there is a clear referral and integrated clinical pathway for those within scope of the project. • Promote the afterhours Primary Health collaborative that goes live in March 2018 to increase access to those vulnerable aged and palliative clients at risk of poor health outcomes without timely coordination. • Integrate to the Healthy Cities programs, in particular the Age Friendly and the Aged Care Charter. Improve coordination of care to ensure patients receive the right care in the right place at the right time, by: • Ensuring the right representation across the key stakeholders to influence within the steering committee. • Building on the relationships to integrate the WACHS Regional palliative model and build on the strong community engagement with the Development Commission, City of Albany and access to expert palliative advice through the Palliative Specialist located at RCS of WA. • Integrating those eligible with the Health Navigator program which supports consumer navigation to 3 levels of service response through telephonic/telehealth, utilising Flinders/partners in health. • Build on the Nurse Practitioner (NP) model for another level of access for comprehensive assessment and timely coordinated care response.

Scalability	As a PHN we recognise the challenges of 'place' in rural palliative care access therefore have planned an integrated approach by supporting other regions across WA to develop resources in building on the CC framework as part of a transferrable design process. During the project, we will have planned communication updates through a range of mediums to other PHN's. This approach will enable visible access to palliative resources that can be customised through the project to suit other regional, rural and remote communities. With the enormous diversity between the Great Southern and Kimberley region (and between all regions in Country WA) there is a commitment to test this approach in the later stages of the project. Project Officers will also interrogate successful outcomes for the implementation of CC Charter in other communities.
Target Population	Long-term or chronic conditions are responsible for most of the burden of disease in Australia. In 2011, cancer, cardiovascular disease, mental health conditions and musculoskeletal disorders were the leading causes of disease burden related to chronic conditions (PHIDU, 2016). Over half of all Australians from regional and remote areas have a chronic condition. The prevalence of chronic illness is higher in these areas (54%) than major cities (48%) (AIHW, 2016b). Target Groups: • Palliative – WACHS Cancer Network/Palliative network /Hospice/ GP / RCS / SCG • Chronic Disease – ICDC / GP / Allied Health / Palliative / Aged Care /WACHS • Aged Care – Community and residential providers /GP / NP / Afterhours / WACHS • Cancer – Cancer Network WACHS • Palliative – WACHS Palliative Care WA Cancer Network / Hospice / Silver Chain / Death Café • Mental health – Palmerston headspace WACHS mental health Clinical workforce including community clinicians and population health clinicians, nurses, doctors, clinical psychologists, Non-clinical workforce including volunteers, artists, and musicians. Including the providers and consumers for Aboriginal and Torres Strait Islander (ATSI) and Culturally and Linguistically Diverse (CALD) who will be effected by this activity Including DHAC networks and other carers support groups.
Coverage	The Great Southern Region, which has an area of 39,007 square kilometres and a population of about 54,000.
Anticipated Outcomes	The anticipated outcomes for preparing for end of life are: • Individuals who have a known life-limiting condition will have choice, quality of care and support though improved referral processes and improved support for families and carers. • LGA will embrace the Compassionate Cities Charter to their communities. • More people with a life-limiting condition will receive end-of-life care in the place of their choice.

	• Unnecessary hospitalisations and avoidable transfers from aged care facilities and community to emergency departments will be reduced. • Referral processes for primary health care providers will be easier. • The burden on families and carers will be reduced, and the support available to them will be improved through the coordination and integration of services.
Measuring outcomes	The Needs Assessment 2017 identified long term expected outcomes and possible performance measures across a range of program areas. This has informed the Outcome Maps that WAPHA has developed in conjunction with service providers to ensure that for each of the four outcome areas there are two mandatory indicators. Utilising this approach, WAPHA will be able to measure change across the four domains to determine how effective services and systems are in relation to: • Patient experience • Patient health outcomes • Service/system integration • Service sustainability including provider experience/governance. An External Evaluator will commence activities from July 2018 and will support PHNs to develop a set of core Key Performance Indicators (KPIs) to inform the national evaluation of the GCfAHPC. Activity related to the development of indicators with the External Evaluator will be reflected in the 2019 Activity Work Plan or an amended version of this plan to be provided in September - October 2018. The key outcomes are likely to focus on: • Individuals who have a known life-limiting condition will have choice, quality of care and support though improved referral processes and improved support for families and carers. • More people with a life-limiting condition will receive end-of-life care in the place of their choice. • Reduction in the number of unnecessary hospitalisations and avoidable transfers from aged care facilities and community to emergency departments will be reduced. • Referral processes/pathway for primary health care providers will be easier. The burden on families and carers will be reduced, and the support available to them will be improved through the coordination and integration of services.
Indigenous Specific	No, however it is designed meet the needs of all Australians including Aboriginal and Torres Strait Islander people.
Collaboration/ Communication	A range of regional organisations will be represented on the project steering committee and have been involved in the planning since the initial expression of interest (EOI) was developed. The Steering Committee for GCfAHPC will work with media for a joint communication on

	the collaborative process and opportunities for community and other stakeholder involvement. Collaborative initiatives already underway are: • **Rural Clinical School** – WAPHA funded Diploma of Clinical Palliative Care (RACGP recognised) the GP graduate will present at the MAC/RCCC and other GP events on the GCfAHPC. Prof Kirsten Auret, is the palliative expert involved in the project design and provides expert support to the steering group. • **City of Albany, Mayor, Executive and Council** - Planned Presentation to council and community on WAPHA role in supporting the GCfAHPC which aligns with the City of Albany Public Health Plan to support the development of Albany as an accessible, connected, safe and sustainable community. Other aligned City projects include Health Tracker; and MyGov digital service portal which will support and integrated with this project. • **Hospice** - A presentation to the board on the role of WAPHA in supporting the project. The Hospice board strategy aligns with CC; use PALCARE and VERA database for volunteers. • **WACHS Regional Coordinator of Palliative Care** – Engagement and relationship to all key events and planning; member of the steering committee. • **WACHS Regional Director and Executive** – A presentation by WAPHA on their role in the project and commitment to supporting staff involvement**.** • **Primary Health Collaborative After Hours GP/NP Palliative/Aged Care** – Five GP practices involved; engagement with the Steering committee regarding potential representation. • **Lower Great Southern Economic Alliance** – Presentations planned to the alliance members (City of Albany and the Shires of Denmark and Mt Barker) to gain commitment from across the region. • **St John Ambulance** – A presentation to the regional office **–** to collaborate on feedback data and have their representation on the Steering committee. • **District Health Advisory Committee** – A Presentation to DHAC and to the Death café. • **Creative Albany** – A presentation on their potential involvement in the project.
Timeline	**STAGE 1 Commences Feb/March 2018** Following onboarding and orientation to WAPHA/City of Albany the Compassionate Communities Coordinator (CCC) position, will commence work to the deliverables within the CC Framework within the City. They will be collocated at times with the Community services team and work closely with the healthy aging team. The second FTE, the Community Palliative Capacity Builder, will be responsible for deliverables as listed (Section 2). During this phase, both these staff will integrate and build relationships and engagement with: • State-wide palliative organisations such as Cancer Network, Palliative Care WA and Silver Chain Group (SCG);

	• Regional palliative care services provided by WACHS/SCG and Integrated Chronic disease programs within community, private and government sectors; • General community sector – referencing to the Community directory (engage and connect in the launch); and • DHAC. Proposed key project milestones: 1. Compassionate Communities assessment – 4th quarter 2017-18: • Environmental scan of Albany and the region to undertake Assessment of the community strengths, discomforts and fears; and • Resource to the National Pal Care projects the application of the Australian Tool Kit for advanced disease and the application of this to a local Community Tool Box resources, including use of Apps and e-learning modules. 2. Focus and commit – 1st /2nd quarter 2018-19: • Formal and public discussions on the concepts within the Charter for Compassion to a local scope and design; and • Identify and work with Community partners to commit to and sign to the Compassionate Charter. 3. Build – 3rd / 4th Quarter 2018-19: • Begin working of and integrating to local action plans which are focused on palliative areas /toolkit/public agenda; • Link the broader regions (including remote) to the CC concept; • Disseminate localised community tool box resources, including exploring linkages with RFDS 'community chests'; and • Utilise available technologies to provide flexible and responsive care, including care after hours. 4. Evaluate and sustain – commence 4th quarter 2020 to project completion: • Monitor and measure (refer to Compassionate Communities Charter Website) against agreed outcomes. **STAGE 2** 1. Extend – 2019-20 • Delivery of a sequence of activities to other parts of the PHN region; and • Assess whether the CC model will function in other regional and remote areas.
Budget (pre-populated)	The PHN 2017-18 to 2019-20 budget for the GCfAHPC Funding stream is provided below. 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 FTE positions (including on-costs)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.