Australian Government
Department of Health

phn
An Australian Government Initiative

Murrumbidgee PHN
Activity Work Plan 2019-2020:
Primary Health Networks – *Greater Choice for At Home Palliative Care*

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. (REF: PC365) Murrumbidgee at-home palliative care program
Description of Activity	**<u>Strategy 1: Capacity/capability building (January - July 2018)</u>** **Establish a working group as part of the Murrumbidgee Palliative Care Alliance and Memorandum of Understanding** Support for community based palliative care approaches across Murrumbidgee, provide project governance, include Palliative Care NSW representative and other key stakeholders. **Recruitment of project staff -** One full time equivalent project manager with experience in community engagement, based in Wagga Wagga, one full time equivalent project officers based in sectors outside Wagga Wagga to facilitate project coverage across region. Responsibilities include; build community capacity across rural communities and promote compassionate communities framework, assist with role clarification and identifying responsibilities for private providers and other community based services and supports, map caring networks, establish local equipment pool/brokerage models and promotion of advance care planning. **Development of HealthPathways** Support general practitioners in assessment, management and referral, promote key enablers currently underutilised in general practice for palliative care support (eg. chronic disease case conferencing and mental health items, NSW Ambulance palliative care plans), link to 24 hour support from specialist palliative care services and NSW Palliative Care After Hours Helpline.

	Building capability in primary care Provide training and community awareness opportunities around advance care planning. Support primary care teams to undertake training through Program of Experience in the Palliative Approach, including clinical placements and other training providers (eg Decision Assist). **<u>Strategy 2: Multidisciplinary telehealth trial (October 2018 – June 2020)</u>** **Commissioning of five trial sites** Undertake expression of interest process for co-design and implementation of localised at-home palliative care solutions, identification of up to five rural communities to be led by general practices, co-design with: consumers and carers, general practice (general practitioners, practice nurses), palliative care team, cancer care coordinators, community nurses, mental health services, NSW Ambulance, government and private providers including social workers, psychologists, speech pathology, physiotherapists, occupational therapists, pharmacy, aged care providers and other community based services, develop local governance arrangements in alignment with the program evaluation plan indicators. **Early identification of palliative care patients in general practice** The 'Surprise Question' or other prognostic triggers tools (eg, Supportive & Palliative Care Indicators Tool) to be built into general practice planning templates and will be the trigger tool for identifying appropriate care pathways. **Multidisciplinary team care planning** Utilise general practice management plans/mental health treatment plans incorporating existing providers such as counsellors and mental health teams, link to existing care coordination services (Murrumbidgee Primary Health Network (MPHN) commissioned services, Murrumbidgee Local Health District (MLHD) integrated care program and cancer care coordinators), work with NSW Ambulance to improve uptake of NSW Ambulance care plans , establish regular multidisciplinary case conferencing, link to existing State funded in-home palliative care support packages. **Identification of patients and carers for telehealth trial** Utilisation of Ipads and Skype for business that may include, but is not restricted to: general practice videoconferencing/case conferencing, patient and carer self-assessments, online patient and carer resources, bereavement support, eligibility criteria for patients/carers to be determined through co-design,

	additional funds made available through MPHN after-hours program to support strategy in after-hours period, MBS items available for mental health clinicians (social workers, occupational therapists and psychologists) for videoconference through Better Access to Mental Health initiative, videoconferencing between general practitioners and specialist services to be established including support for patients who have accessed specialist services outside of local health districts and referred back to local general practitioners, purchase equipment and provide training to patients and carers, general practice team, the palliative care team and other clinicians. **Establish an afterhours pathway within each community** Identify contact pathways for patients and carers, promote access to the 24 hour support service through St Vincent's Hospital and through Decision Assist line and NSW Palliative Care After Hours Helpline for general practitioners and aged care providers, promote NSW Ambulance care plans to assist in after-hours coverage in rural regions. **Evaluation including Patient assessment and outcome measures** Palliative Care Outcomes Collaboration (PCOC) assessment tools incorporated into local models with data shared with MPHN and evaluation team engaged by the Department, PENCAT data utilised to identify appropriate process measures from general practice to support ongoing quality improvement, participation in evaluation and ongoing quality improvement to embed changes in practice. **Linking with current governance arrangements** The project will engage with local communities through the MPHN Community Advisory Committee (CAC) and Clinical Councils. The CAC is informed by 33 Local Health Advisory Committees (LHAC) from across the Murrumbidgee region and provides input to the Board. The Murrumbidgee Palliative Care Alliance and working group will provide the governance structure to support the development of local community led palliative care approaches and will be responsible for the oversight of the project activities. Executive level sponsorship will be identified by MPHN and MLHD and will be represented on the Alliance. In addition, MPHN Clinical Governance Committee will have oversight of the project to ensure high quality and safe services are provided particularly in relation to the use of telehealth.
Rationale/Aim of the Activity	MLHD have implemented the NSW Agency for Clinical Innovation model for Palliative and End-of-Life Care which has primary care providers at its core. Although speciality services exist in some regions,

	focus is on the care delivery by primary care providers within each community. Future strategic direction is to place speciality services in hubs across the local health district by the end of 2017 so that residents are within a two hour radius, with outreach and telehealth being used to provide care where there is no fulltime speciality nursing available. The local health district palliative care team will be instrumental in working with primary care providers to establish local approaches to in-home palliative care and these local models of care will supplement the overarching MLHD palliative and end of life care service model. Consultation with MPHN Clinical Councils, palliative care team, general practice and public/private primary care providers identified gaps and areas for improvement to support in-home palliative care approaches: • Use of technology eg. iPads to improve access to afterhours care • Improve multidisciplinary care planning • Improve uptake of NSW Ambulance protocols • Ensure equity of access to equipment • Embed advance care planning in chronic disease management planning • Development of private and public partnerships • Training and education for GPs and primary care team • HealthPathways to improve early referral to allied health, social workers, psychologist • Engaging local community support groups
Strategic Alignment	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 unplanned 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. The Murrumbidgee at-home palliative care program meets the stated objectives in its design and implementation for the benefit of palliative care patients in the community.

	MPHN has a higher incidence of cancer, an older population particularly with higher rates of living alone and a higher Aboriginal population with high rates of hospitalisations and lack of access to palliative care services due to its rural and remote profile.
Scalability	MPHN has specifically designed its project to include an expansion and sustainability phase. Additionally the MPHN will ensure it documents the project in detail and captures significant learnings from design through to evaluation that ensure the replicability of the project in other PHNs should it achieve a successful outcome. In doing so the information dissemination evaluation indicators will be satisfied. Phase 3 is as follows; **Strategy 3: Expansion and sustainability (April 2020 – June 2020)** Effective dissemination of new and enhanced models of care to other practices across the region and disseminated at NSW and National palliative care conferences.
Target Population	MPHN is located in the south-west of NSW and covers a large geographic area with a population of 242,191, with 40% living in a remote or outer regional area. Approximately 5.1% of the population identify as Aboriginal or Torres Strait Islander peoples, double the State rate. Aboriginal people in the MPHN have a lower life expectancy and higher rates of hospitalisation compared to state averages. The median age is higher in the MPHN compared to the NSW average with a higher proportion of people in the 65+ age groups (18.9% and 15.7% respectively). Strategy 1 will target local community members to promote the compassionate communities framework and to map caring networks. As part of Strategy 2, the MPHN will; • Identify up to five rural communities to be led by general practices • co-design with: consumers and carers, general practice, palliative care team, cancer care coordinators, community nurses, mental health services, NSW Ambulance, government and private providers including social workers, psychologists, speech pathology, physiotherapists, occupational therapists, pharmacy, aged care providers and other community based services. • The target patient group/diagnosis for this phase will be determined through co-design.
Coverage	MPHN will consult the Health Needs Assessment for 2017 to determine the areas which are likely to be optimal for delivery of the program and will also aim to engage two sites in each of the three rural sectors (Riverina, Border and Murrumbidgee), excluding Wagga Wagga.
Anticipated Outcomes	**Outcomes include** Improvement in the early engagement of patients in the palliative approach through general practice.

	Reduction in unplanned hospitalisations and avoidable transfers from aged care facilities to emergency departments. Greater choice of where palliative care occurs for patients requiring palliative care in the community. Patients will have access to primary care services and medications to enable them to stay in their home. Real time support will be available for family and carers when needed, especially in the after hours period. Patients and their family/carers will have access to equipment to support them to stay in their own home. Primary care providers will have knowledge of and will accessed HealthPathways relating to palliative care for health care professionals. Improved support to palliative care patients through the coordination and integration of services and access to support through the use of telehealth technologies where applicable. Two trial sites in communities across the Murrumbidgee will have adopted and be working towards the compassionate communities' framework, with a further three sites to undertake activities in a staged approach. Improvement in generating data through utilisation of PCOC or other data gathering resources in alignment with the evaluation indicators.
Measuring outcomes	The five trial sites commissioned to co-design and implement local strategies will be contracted to provide data according to a minimum data set and reporting schedule. The minimum data set will be developed through the co-design process and will include patient and carer reported outcome measures. All local communities implementing community education strategies will be required to undertake pre and post evaluation.
Indigenous Specific	This activity is not Indigenous specific however it is recognised that the region has a significant Indigenous population.
Collaboration/Communication	The Compassionate Communities framework will underpin the community engagement strategies and intended outcomes. This framework relies on the identification of existing caring networks and aims to normalise help seeking from family, friends and neighbours. Network mapping will support the development of resources to promote local community support networks and information will be incorporated into HealthPathways for general practice and be made available through local community avenues. Local Health Advisory Committees are a central connection between the local community and health services and work with local health and primary care to identify local service needs and areas for

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<tr><td></td><td>improvement. These committees are jointly supported by the MPHD and MPHN. MPHN have worked successfully with a small number of LHACs to identify local aged care needs and promote advance care planning and will build on the success of this approach. Project funding will be made available to LHACS to support community network mapping process (including stakeholder meetings, survey, interviews) and implementation of community strategies to meet identified needs. Information obtained will be included in the development of care pathways/networks for each community. This approach will aim to strengthen the establishment of strong networks with both community groups and also health professionals, in alignment with the program's network evaluation indications.</td></tr>
<tr><td>Timeline</td><td>Phase 1: Capacity/capability building (January - July 2018)
Phase 2: Shared care planning and telehealth trial (October2018 – June 2020)
Phase 3: Expansion and sustainability (April 2020 – June 2020)</td></tr>
<tr><td>Risk Management</td><td>
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<tr><th>Risk</th><th>Risk rating</th><th>Mitigation</th></tr>
<tr><td>Delay in recruitment of project staff</td><td>Low</td><td>Commence recruitment once contract received and ensure wide promotion of positions. Promote through local networks.</td></tr>
<tr><td>Limited uptake of community engagement strategies by LHACs</td><td>Low</td><td>Early engagement of LHACs through provision of project information via MPHN primary care engagement team and through MPHN Community Advisory Committee.
Engagement of LHACs in designing and supporting phase one of the project.</td></tr>
<tr><td>Nil uptake of training opportunities by general practitioners and other health professionals</td><td>Low</td><td>Obtain input from primary care providers on content and delivery methods for training. Ensure early promotion of identified training opportunities through multiple avenues.</td></tr>
<tr><td>Limited uptake by general practices of the telehealth and shared care planning trial</td><td>High</td><td>Local engagement in palliative care discussions has indicated that there is support.
Communication plan and engagement of practices for the expression of interest.
Early promotion of project activities and anticipated outcomes to general practices and their community.</td></tr>
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			Appropriate budget developed to ensure funding is adequate for general practices to be engaged in the project. Appropriate timelines allocated to co-design processes, based on previous co-design experiences.
	HealthPathways are at capacity and unable to upload pathways within timeframes specified	Low	Notify Streamliners early of pending pathway development and anticipated release date.
	Competing demands for existing staff engaged in the project	Medium	Executive sponsors to regularly review capacity with staff to ensure they have adequate support and time to carry out project requirements.