Australian Government
Department of Health

phn
An Australian Government Initiative

# Primary Health Networks: Greater Choice for At Home Palliative Care Funding Activity Work Plan: 2017-18 to 2019-20

***Western NSW Primary Health Network***

# Introduction

## Overview

The key objectives of Primary Health Networks (PHN) are:

- increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- improving coordination of care to ensure patients receive the right care in the right place at the right time.

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

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2017-18 to 2019-2020 These activities will be funded under the *Greater Choice for At Home Palliative Care* Funding stream under the Schedule – Primary Health Networks Core Funding.

| Proposed Activities | Description |
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| Activity Title | *The SHARE (**S**hared **H**ealth and **A**dvance Care **R**ecord for **E**nd of life choices) Project: implementing a shared Palliative Approach across Far West and Western NSW* |
| Description of Activity | **Introduction**<br>The SHARE (**S**hared **H**ealth and **A**dvance Care **R**ecord for **E**nd 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. The paper-based FWPAF suite of clinical and educational tools and resources has achieved sustained improvements in advanced care planning, care coordination and quality of PEoLC in line with patient wishes in RACFs and Multi-Purpose Service (MPS) facilities, as well as reduction in unnecessary hospital admissions. When translated into all care settings, including community, primary health, General Practice and hospital services, it will provide a shared framework to provide genuine choice that enables the right care, at the right time, in the right place.<br><br>Implementation of this project in Western NSW Primary Health Network (WNSW PHN) includes two stages:<br>**Stage 1**<br>**(April to June 2018):**<br>Engage a Business Analyst (BA) contractor to undertake the business analysis required for the FWPAF to be developed into an Electronic Palliative Approach Framework (ePAF) for implementation in community and primary health care settings across |

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| | WNSW PHN, incorporating FWLHD and Western NSW Local Health District (WNSWLHD). The role will be responsible to undertake business analysis with key stakeholders to derive the clinical workflow and map the current gaps to design and document the technical solution required for the development of the ePAF shared health and advance care record.<br><br>**(June 2018 to June 2019):**<br>Engage an Information and Communication Technology (ICT) contractor to:<br>• Develop and configure a shared care platform package solution to connect My Health Record, General Practitioners, the Local Health Districts and Residential Aged Care Facilities.<br>• Scope and develop the FWPAF into the ePAF for implementation into community and primary health care settings across WNSW PHN, incorporating FWLHD and WNSWLHD. The ePAF will be a shared locality record that crosses care boundaries, provides all clinicians with timely access to key information, enables provision of reliable, safe and appropriate care, consistent with patient wishes, at any time of day or night.<br>• Develop a data collection and extraction dashboard to monitor clinical care through evidence-based outcomes indicators and inform continuous improvement of services across all care sectors.<br><br>**(July 2018 to June 2019):**<br>Recruit a Palliative Approach Project Coordinator (PAPC) 0.2 FTE to:<br>• Support the WNSW PHN Clinical Projects Manager with project coordination, including coordinating the inter-organisational project governance as listed below.<br>• Engage a contracted web developer (from July 2018 to Sept 2018) to upload the FWPAF and associated clinical and educational tools onto the WNSW PHN website to be a resource for GPs and clinicians in all other care settings to access to support the ePAF shared care record.<br>• Work with the WNSW PHN Practice Support Team (from Oct 2018 to Dec 2018) to undertake the change management processes required to implement and evaluate the web-based FWPAF resource in preparation for the implantation of the ePAF shared health and advance care record.<br><br>**Stage 2**<br>**(July 2019 to Jun 2020):**<br>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:<br>• One General Practice and one MPS in FWLHD<br>• Two RACF in WNSWLHD<br>The implementation programme in each LHD will allow PALOs and SPCTs to provide focused and localised planning, development, implementation, sustainability and evaluation activities at each site; mirroring the sustainable implementation method used in FWLHD RACF and MPS sites to date. In addition, the PALOs will work with the WNSW PHN Practice Support Team and Digital Health Officers to integrate with the earlier clinical change and adoption activities undertaken throughout the PHN during the implementation of the web-based FWPAF resource and My Health Record respectively. |

**Situation**

In September 2017, when the *Greater Choice for At Home Palliative Care* funding Expression of Interest (EOI) was submitted by WNSW PHN, the intention was to build on the work already being undertaken by FWLHD to develop a web-based electronic integrated care record connecting GPs, primary health and LHDs, and with this project, also expanding into RACFs. However, during January 2018 WNSW PHN was notified that this work has been delayed by eHealth NSW while they develop a single set of requirements that meets the needs for shared care planning across the Local Health Districts and that eHealth NSW will undertake a Tender process. In addition, further consultation with Western NSW Health Intelligence Unit, (HIU), eHealth NSW, and the Australian Digital Health Agency has identified the need to ensure that the ePAF developed by this Project is able to interface with Health eNet (NSW State) and My Health Record (National) in the future. Therefore, the commencement of the project has been delayed for WNSW PHN to research appropriate Business Analyst (BA) and Information and Communication Technology (ICT) contractors to map, scope and develop the FWPAF into the ePAF.

A clarification meeting held on the 2 February 2018 with the DoH resulted in the agreement that:

- WNSW PHN will seek to employ an Information and Communication Technology (ICT) contractor to scope and develop the ePAF
- This activity will be reflected into the Activity Work Plan scheduled for submission from 16/2/18 onwards and provided by 2/3/2018 at the latest.

**Background**

The Greater Choice for at Home Palliative Care Work Group held pre-planning meetings on the 8 December 2017 and 30 January 2018 to inform the 2.0 FTE break up, type and distribution across WNSW PHN region; the role and responsibilities of the positions, recruitment, timeframes and service agreements.

The 2.0 FTE roles were to include three part-time positions as follows:
Configuration Officer fulltime for 3 months; Project Coordinator, Far West region – RACF Palliative Approach Linkage Officer, Western NSW – RACF Palliative Approach Linkage Officer.

Because the FTE for the BA and an ICT contractor (as detailed in Stage 1) is not known at the time of writing this Activity Work Plan, WNSW PHN is unable to provide information regarding the identification of the 2 x FTE roles including title of positions, role functions and responsibilities; a detailed implementation methodology, or how the activities will achieve the objectives of the GCfAHPC Project.

WNSW PHN will be able to provide updated details of the 2 x FTE roles (as requested) when the FTE for Business Analyst and an ICT contractor is known. The quantum of FTE and subsequent funding required to scope and develop the ePAF during **Stage 1** will have a direct effect of the breakup of FTE required for **Stage 2**.

**Assessment**

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| | Due to the Christmas closure and major barriers experienced since being notified that WNSW PHN EOI for the *Greater Choice for At Home Palliative Care* measure was successful, progress has been delayed and **Stage 1** needs to be completed before **Stage 2** can commence.<br><br>Far West LHD has been advised by the NSW Ministry of Health (MoH) and NSW eHealth to hold off on procurement with vendors to develop a shared health care record until further notice as a State-wide solution is under development.<br><br>FWLHD Project Manager Integrated Care will be meeting with the eHealth NSW, Executive Director System Performance Support in Sydney on the 2 March 2018 to discuss the potential to utilise the Extensia platform as a pilot in Broken Hill for the chronic disease, integrated care, and the palliative care.<br><br>WNSW PHN is currently researching appropriate Business Analyst and an ICT contractor to scope and develop the ePAF. Discussions with eHealth NSW and the Australian Digital Health Agency (ADHA) have occurred to explore opportunities to link into the work being undertaken by both agencies.<br><br>During a meeting held 23 February 2018 Australian Digital Health Agency Rupert Lee, General Manager - Programmes and Delivery Government and Industry Collaboration recommended a further meeting to be organised with Clinical Professor Meredith Makeham, Chief Medical Adviser for the ADHA.<br><br>**Recommendation**<br>Request the Department of Health approval to move the Stage 1 timeframe for the engagement of a Business Analyst and an ICT contractor to scope and develop the ePAF as detailed below:<br>**Stage 1**<br>**(April to June 2018):** Business Analyst (BA) contractor<br>**(June 2018 to June 2019):** Information and Communication Technology (ICT) contractor<br>**(July 2018 to June 2020):** Recruit a Palliative Approach Project Coordinator (PAPC) 0.2 FTE.<br><br>Further information relating to the **Stage 1** activities will be provided to the DoH after the BA and ICT contractors have been engaged.<br><br>**Governance**<br>Project governance will be incorporated into current WNSW PHN Corporate Governance arrangements using established relationships with local communities and key stakeholders including; FWLHD and WNSWLHD and their respective SPCTs, RACFs, GPs and consumers. |

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| | Governance will include establishment of a project working group with representation from WNSWPHN, FWLHD, WNSWLHD, both LHD SPCTs, RACFs, MPSs, GPs and NSW Ambulance. This group will provide project reports to FW and WNSWLHDs Integrated Care Strategy Steering Committees (ICSs), FWLHD PEoLC Steering Committee, WNSW LHD PEoLC Clinical Stream, both LHD and WNSW PHN Clinical Councils. The WNSW PHN Aboriginal Health Council, Far West and Western Community and Clinical Councils will be used to engage Aboriginal people, clinical networks, consumers and communities. These Councils will provide input into the co-design of the palliative approach system improvement model.<br><br>In addition, during **Stage 1**, existing PHN representation on both LHD ICSs will provide governance of the shared ePAF development with linkages to My Health Record and Health eNet development and the regional electronic integrated care strategies.<br><br>This project addresses recommendations within National Palliative Care Strategy, NSW Agency of Clinical Innovation (ACI) PEoLC Blueprint, NSW Rural Health Plan and NSW Integrated Care Strategy (ICS). It links with work already undertaken in the locality in partnership with NSW Health, ACI and University of Sydney Department of Rural Health, Broken Hill (BHUDRH). Progress and outcomes will be reported to peak state bodies through current reporting lines to NSW Health and NSW Office for Health and Medical Research, and existing local representation on ACI Palliative Care Executive Network and Palliative Care NSW Executive Committee. |
| Rationale/Aim of the Activity | National, State, and local Primary Health Network (PHN) and Local Health District (LHD) policy objectives promote the provision of patient-centred high-quality palliative and end of life care for rural and remote residents, either at home or as close to home as possible. A palliative approach to care has been well documented to improve patient care and outcomes at the end of life, including fewer admissions to hospital in the last year of life and increased deaths at home.<br><br>In the Far West LHD (FWLHD), of the approximate 170 expected deaths that occur every year, 51% (cf 26% NSW) access care from Specialist Palliative Care Services (SPCS). Of those known to the SPCS, 98% (cf 25% Australia) have their end of life wishes documented, and 99% are cared for and die in the place of their choosing, including 33% (cf 16% Australia) at home. Whilst not every dying person requires SPCS input, the access to, quality and outcomes of the palliative care provided by non-specialist services in the FWLHD is unknown.<br><br>To address these strategies and identified gaps, and based on the care provided by the Far West SPCS, the Far West Palliative Approach Framework (FWPAF) was developed by pulling together clinical and educational resources to build capacity and improve provision of comprehensive, consistent, patient-centred, needs-based, high-quality palliative and end-of-life care for all, irrespective of diagnosis, care location or care provider.<br>The Far West Palliative Approach Framework (©FWLHD2016) consists of:<br>• overarching principles (model of care) of a palliative approach that can be applied to and used with patients in any care setting: acute and sub-acute hospitals, multi-purposed facilities, residential aged care facilities (RACFs), community and primary health services and general practice<br>• a practice framework, including: |

- specific validated clinical tools for each of the five phases of palliative care embedded within the Framework
- educational resources to assist engagement with and use of the clinical toolkit
- policy and practice documents to implement the Framework, guide the provision of care, and embed the Framework activity

- an evaluation framework, providing audit tools to assist local services to continually demonstrate the clinical impact (improved patient outcomes) and educational impact (increased training, development, and support to build and sustain local clinicians) of the Framework
- an implementation framework, providing resources to assist the engagement, education, training, and mentoring required to successfully adapt, implement, embed, and sustain the Framework (currently being evaluated through a 2-year NSW Health Translational Research Grant Scheme (TRGS) funded research project in partnership with the University of Sydney Department of Rural Health Broken Hill (UDRHBH)).

The Far West Palliative Approach Framework practice framework (clinical toolkit) includes a FWPAF Resident/Patient Checklist, which guides the care for individual patients through each of the palliative care phases in line with evidence-based best practice.

This will form the basis of the Electronic Palliative Approach Framework (ePAF), behind which will sit electronic links to signpost clinicians to clinical and educational tools and resources. It is intended that the ePAF will become a shared locality record that can cross care boundaries, providing all clinicians with timely access to key information, enabling provision of reliable, safe and appropriate care, consistent with patient wishes, at any time of day or night.

It is intended that the ePAF will generate data to monitor clinical care through EMU (The End of Life Minimal Universal Tool), an evidence-based generic set of outcomes indicator that has been developed to audit, monitor and benchmark provision of palliative and end of life care by all care providers in all care settings.

In a study that compared all resident deaths in within the Residential Aged Care Facilities (RACF) in the 6 months pre- and post-implementation of the FWPAF in paper format, it was demonstrated to provide an acceptable, sustainable, and contextually-fit approach to enhance the local provision of quality palliative and end of life care in RACFs by:

- improving clinical outcomes for patients approaching the end of their lives, and their families and carers, including:
  - earlier identification of patients approaching the end of their life (increased from 54% to 85%; p=0.001)[1]
  - improved advance care planning (increased from 46% to 76%; p=0.03)[1], documentation of end of life care wishes (increased from 51% to 76%, p=0.014)[1], and adherence to these wishes (increased from 35% to 57%, p=0.038)[1]
  - improved access to and use of end of life medications
  - provision of quality palliative and end of life care within local communities; including avoiding admission or transfer to distant hospitals (decreased from 84% to 37%)[1], and
  - promoting dying in the RACF as their usual place of residence (increased from 31% to 60%, p=0.003)[1]

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| | • building and maintaining an upskilled rural and remote RACF, Primary Care and GP workforce with demonstrated increased knowledge, skill, and confidence to provide a quality palliative approach to care through mentoring and education programs[2]<br><br>• enhancing communication, integration, and collaboration between RACFs, GPs, SPCS and acute hospitals<br>- improved multi-agency multidisciplinary case conferencing for patients in the last year of life (increased from 14% to 38%, p=0.01), and associated clinical documentation (increased from 49% to 84%, p<0.01)[1]<br><br>• extending capacity of the Far West LHD Specialist Palliative Care Service<br>- increase in palliative approach being provided by GPs and RACF staff, with associated decrease in referrals to SPCS from RACF (decreased from 52% to 27%, p=0.039)[2]<br>- associated decrease in SPCS occasions of service for residents in RACF[3]<br>- increase in prescribing of anticipatory medications in the last days for RACF residents by GP rather than SPCS (increased from 67% to 93%, p=0.041)[2]<br>- increase in total number of referrals to SPC service (increased from 115 to 119), associated increase in SPC service events and deaths of SPC patients (increased from 76% to 95%) during the same time period[3]<br><br>A NSW Health Translational Research Grant Scheme (TRGS) funded research project is currently evaluating the adaption and implementation of the FWPAF to other rural and remote healthcare sites (subacute hospitals and MPS facilities) across the Far West LHD. The ultimate vision is for the FWPAF (and ePAF) to be implemented and sustained across all care settings across the Far West LHD, to ensure coordinated, comprehensive, consistent, patient-centred, needs-based, high-quality palliative and end-of-life care for all.<br><br>It is anticipated that the development and implantation of the ePAF through this SHARE project will achieve similar improvements in clinical outcomes for patients and their families, professional development for primary health care clinicians and capacity building for specialist palliative care services.<br><br>**Data Sources:**<br>1. Far West Palliative Approach Framework Southern Cross Care RACF Clinical File Audit (Unpublished - Smith, Saurman and Wenham 2017)<br>2. Far West Palliative Approach Evaluation: Southern Cross Care Short Report (Saurman, Lyle, Wenham and Cumming 2018)<br>3. Far West LHD Specialist Palliative Care Team KPI Data (Unpublished - Wenham 2016). |
| Strategic Alignment | The SHARE project aligns with the national PHN objectives of:<br>• increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and<br>• improving coordination of care to ensure patients receive the right care in the right place at the right time |

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| | The project also aligns to the four regional goals for WNSW PHN:<br>1. Improve health outcomes through service integration<br>2. Work in partnership to improve Aboriginal health outcomes<br>3. Develop high quality programs and services<br>4. Support the development of a sustainable primary health workforce<br><br>Through this project, there is alignment with the WNSW PHN Needs Assessment 2017 in the identified need of Integration and Collaboration. Disconnected care and poor communication and collaborating between providers has been identified as a key issue. Previous Needs Assessments and stakeholder consultation strongly confirmed the need to focus on better connections between service providers, and improved integration of care. Some of the specific issues raised include: inconsistent discharge planning, poor awareness of available services and lack of coordination, duplication of services by different providers in a location in some instances, insufficient networking and interagency collaboration and service planning not coordinated across service providers. There was a particular emphasis on the need for improved coordination of care for disadvantaged patient groups and at-risk populations.<br><br>The development and implementation of the ePAF is a collaborative partnership with the Far West and Western NSW LHDs. This regional alliance to implement an ePAF across care boundaries through a Shared Health Record will result in improved integration of care and assist to make significant gains in the care available to people with advanced life limiting illnesses and those approaching the end of their life. |
| Scalability | • Building on the successful pilot within Stage 2 of this project, a staged roll out of the FWPAF and ePAF will be implemented across the remaining General Practices, Primary Health, MPS and RACF sites throughout FWLHD and WNSWLHD. This will enable:<br>- Equitable access to high quality palliative and end of life care in all care settings, providing genuine choice that enables the right care, at the right time, in the right place.<br>- Development of palliative care knowledge, skills and confidence for GPs, Primary Health, RACF and LHD throughout the WNSW PHN footprint<br>• As this SHARE project is building on research already being undertaken by the FWLHD in partnership with the University of Sydney Department of Rural Health Broken Hill (UDRHBH), funded through a NSW Health Translational Research Grant Scheme (TRGS) grant, if successful, the ePAF can be incorporated into the FWPAF translational implementation framework, that will provide resources to assist the engagement, education, training, and mentoring required to successfully adapt, implement, embed, and sustain the FWPAF and ePAF within other LHDs and PHNs<br>• With the National My Health Record Expansion Program now underway, both LHDs and the PHN will work with eHealth NSW and the Australian Digital Health Agency to integrate the ePAF shared care record and advanced care plans into Health eNet and My Health Record respectively. There is future potential for the IT solution developed as a result of this SHARE project to bridge any remaining gaps and jointly develop the MyHR, eHealth NSW, LHD, GP, Allied Health, and NGO systems nationally |

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| | • Defining coordination and implementation role of Integrated Care Navigators and Practice Nurses in GP and Primary Health settings beyond integrated palliative care, into patient's health journey through integrated chronic care and integrated primary care<br>• Appointment of Registered Nurse Palliative Approach Liaison Officers in each of the RACFs and MPSs involved in the project<br>• The use of consistent KPIs and data collection items that are outcome focused for Palliative Care will enable tracking and benchmarking of patterns of care, and informing of future service development, locally, at state and national level.<br>• Building of knowledge, skills and capacity of PHN and partner LHD staff in health informatics and IT systems, along with development of relationships, partnerships and networks between the LHDs and PHN with state, national and corporate health IT agencies. |
| Target Population | It is intended that this activity, when rolled out across the whole PHN, will impact the clinical care of the 2062 residents (0.66% of the 310,573 population), and their relatives and carers, of the WNSW PHN footprint who die an expected death every year (75% of the total 2,750 deaths). These are patients with a known life-limiting illness (such as incurable cancer, end-stage heart failure, end-stage COPD, end-stage renal failure, incurable neurological disease, etc) who are identified as being in the last 12 months of life.<br><br>For Stage 2 of the activity, the pilot will be based at four sites, and the impact the clinical care of the patients and residents cared for within each of these care settings (numbers to be advised in the next AWP):<br>• One GP Practice in Broken Hill (FWLHD region)<br>• One MPS in Balranald (FWLHD region)<br>• Two RACFs in WNSWLHD region (to be decided).<br><br>For Stage 1 of the activity, the target clinician population affected by the implementation of the web-based FWPAF resource includes all General Practitioners, Primary Health Care Nurse, MPS Nurses, RACF Nurses, Specialist Palliative Care Team, NSW Ambulance Officers, Hospital Doctors and Nurses, Local Health District staff and Primary Health Network staff that are involved in the clinical care of patients and their relatives in the last year of life. This includes 332 GPs working out of over 100 General Practice locations, and nursing staff working within the 27 MPS facilities and 62 RACFs.<br><br>In addition, for Stage 2 of the activity, the target clinician population affected by the pilot implantation of the ePAF shared health and advance care record will include the medical and nursing clinical staff at each of the four pilot sites (numbers to be advised in the next AWP):<br>• The GP Practice in Broken Hill (FWLHD region); number of GPs and Practice Nurses<br>• The MPS in Balranald (FWLHD region): approximately 1 GP and MPS Community, In-patient and RAC Nurses<br>• The two RACFs in (WNSWLHD region): number of GPs and RACF Nurses<br>In addition, the clinical services that work in partnership with each of these pilot sites, will also be affected by this activity, including FWLHD and WNSWLHD Specialist Palliative Care Medical and Nursing staff, NSW Ambulance Officers, as well as the Medical and Nursing staff of the local LHD acute facilities. |

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| Coverage | Western NSW Primary Health Network (WNSW PHN) covers both Far West and Western NSW Local Health Districts across a total area of 433,379 square kilometres, making it the largest PHN in NSW (at 53.5%). The total population is estimated to be over 309,000 people, with 17.5% over the age of 65 years (ABS, 2014). Approximately 11.7% of people in our region identify as Aboriginal and Torres Strait Islander. WNSW PHN supports 332 General Practitioners that operate from over 100 GP practices in our region (HWA, 2014). |
| Anticipated Outcomes | The anticipated outcomes and benefits of this activity are listed below (the outcomes as listed are reliant on the development of the ePAF and are likely to be further refined during the project, because of this a timeframe has not been incorporated).<br><br>**Primary outcome measures**<br>• Numbers of patients with a ePAF record<br>• Numbers of clinicians (GP, Primary Health Care Nurse, MPS Nurse, RACF Nurse, SPCT, hospital ED and Inpatient team staff, allied health, chronic care team, renal team, medical and radiation oncology clinicians) who are using the ePAF to upload and view information<br>• Number of clinicians accessing FWPAF resources (website hits)<br>• Improved knowledge, skills and confidence of GPs, Primary Health, LHD, MPS and RACF in order to provide a quality palliative approach to their patients<br><br>**Clinical secondary outcome measures**<br>It is intended that the ePAF will generate data to monitor clinical care through EMU (The End of Life Minimal Universal Tool), an evidence-based generic set of outcomes indicator that has been developed to audit, monitor and benchmark provision of palliative and end of life care by all care providers in all care settings. EMU has been designed to accompany the FWPAF and fit with the ACI Palliative and End of Life Blueprint Essential Components. (EMU: The End of life Minimum Universal clinical quality and outcomes reporting tool, (Unpublished: Saurman, Hutchinson and Wenham 2016)). Refer to page 16.<br><br>**Improve earlier identification of patients requiring a palliative approach to care**<br>• ↑ identification of patients in their last year of life<br>• ↑ identification of palliative care phase<br>• ↑ identification in earlier palliative care phase<br>**Improve advance care planning**<br>• ↑ documentation of patient wishes<br>• ↑ documentation of person responsible<br>• ↑ documentation of preferred place of care<br>• ↑ documentation of preferred place of death<br>**Improve coordination of care**<br>• ↑ coordination of care |

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| | • ↑ communication between healthcare professionals<br>**Improve quality of care**<br>• ↑ holistic assessment of patient needs<br>• ↑ care provided in accordance with assessed need<br>• ↑ care provided with adherence to patient wishes<br>• ↑ care provided in place of patient choosing<br>**Improve care in last days of life**<br>• ↓ non-essential treatments in terminal phase<br>• ↑ essential care in last days of life<br>• ↑ deaths in place of patient choosing<br>**Improve family/carer support**<br>• ↑ assessment of family/carer needs<br>• ↑ support provided in accordance with assessed need<br>**Improve bereavement support**<br>• ↑ bereavement support |
| Measuring outcomes | *Note - 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 should be reflected in the 2019 Activity Work Plan.*<br><br>**Primary outcome measures**<br>It is anticipated that the technology solution underpinning the ePAF will be a cloud based, centrally hosted solution that will allow usage metrics to be analysed. These metrics are planned to include:<br>• Number of providers registered to the solution (and change / trend over time)<br>• Number of consumers registered (and change / trend over time)<br>• Number of patients with an ePAF (and change / trend over time)<br>• Date of last update of each ePAF<br>• Average currency of ePAFs (and change / trend over time)<br>• Average frequency of update of ePAFs (and change / trend over time)<br>• Number of views of each ePAF, segmented by healthcare provider type (and change / trend over time)<br>• ePAF activity summarised by healthcare provider organisation<br><br>The educational primary outcomes listed above will be assessed, evaluated and monitored through a staff educational survey (based on the FWLHD paper staff survey) designed to knowledge, practice, attitude and confidence regarding a palliative approach to care: |

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| | - Completed all GPs, Primary Health care, MPS and RACF staff by at Stage 1 baseline (July 2018) and mid-point (June 2019), coordinated by the PAPC to determine the effectiveness of the development and implementation of the webbased FWPAF resource<br>- In addition, for the GP, MPS and RACF staff of the three pilot sites, survey completed again at project end (June 2020), coordinated by the PALOs, to determine the additional educational improvements gained through the implementation and use of the ePAF in clinical practice.<br><br>**Secondary outcome measures**<br>The clinical secondary outcomes listed above (in Anticipated Outcomes) will be assessed, evaluated and monitored through:<br>- At stage 2 baseline (July 2019) clinical case note audits of the three pilot sites using the FWLHD paper clinical audit tool, undertaken by the PALOs to determine baseline key clinical indicators<br>- Subsequently, it is the intention that all key clinical indicators will be seen on a clinical dashboard within the ePAF in real time<br>- At project end (June 2020), key clinical indicators benchmarking reports will be pulled directly from the ePAF by the PALOs to determine the effectiveness of the implementation of the ePAF in the three pilot sites. |
| Indigenous Specific | This activity is not specifically targeted for Aboriginal and Torres Strait Islander peoples. However, From PHIDU using the latest available 2016 URPs (Australian Bureau of Statistics (ABS) Census 2016), WNSW PHN had the highest proportion of its total population identifying as Aboriginal (10.5%) of all NSW PHNs, and the third highest nationally behind the Northern Territory and Western Queensland PHNs.<br><br>The FWLHD has the highest Aboriginal and Torres Strait Islander population within NSW (9.7% population cf 2.8% NSW and 3.3% Australia). The FW SPSC has developed strong partnership working relationships with the Broken Hill and Dareton Aboriginal Medical Services to both provide clinical care and develop and implement the FWPAF. As a result, the Aboriginal community has demonstrated engagement with the FWLHD SPCS, with a significantly higher utilisation of palliative care services comparatively to known state and national data: 8.9% patients known to FWLHD SPCS identify as Aboriginal (92% of 9.7% FWLHD Aboriginal population), compared to 1.7% patients accessing palliative care services within NSW identify as Aboriginal (61% of 2.8% NSW Aboriginal population) and 1.4% patients accessing palliative care services throughout Australia identify as Aboriginal (42% of 3.3% National Aboriginal population).<br><br>WNSW PHN has implemented a Cultural Safety Framework that will further inform the PAF. This will ensure all palliative services for Aboriginal patients in the region are supported to better appreciate the cultural strengths, values, knowledges and norms required to improve the health status of our Aboriginal population. The governance arrangements described above include representation from the Aboriginal Medical Services organisations on each of the named interagency committees. In addition, the WNSW PHN Aboriginal Health Council, Far West and Western Community and Clinical Councils will be used to engage Aboriginal people. |

| | |
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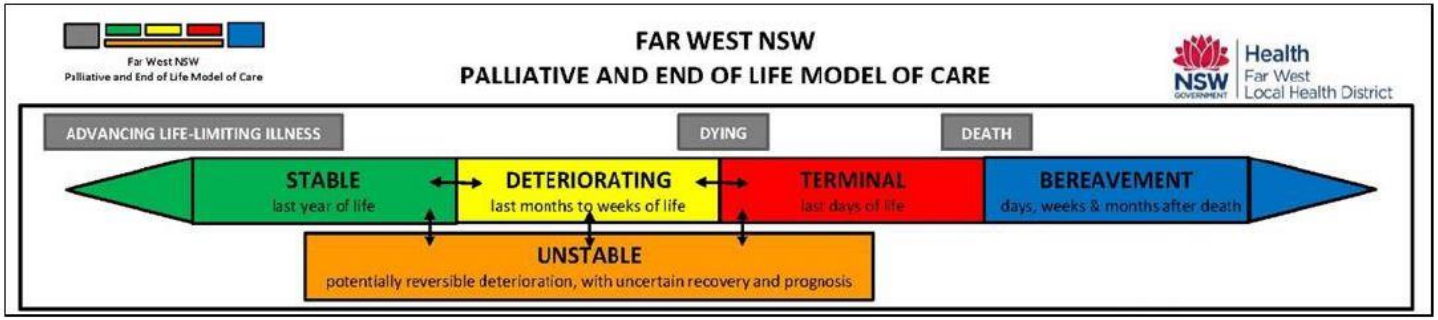
| Collaboration/Communication | This proposal addresses recommendations within National Palliative Care Strategy, NSW Agency of Clinical Innovation (ACI) PEoLC Blueprint, NSW Rural Health Plan and NSW Integrated Care Strategy (ICS). It links with work already undertaken in the locality in partnership with NSW Health, ACI and University of Sydney Department of Rural Health, Broken Hill (BHUDRH). Progress and outcomes will be reported to peak state bodies through current reporting lines to NSW Health and NSW Office for Health and Medical Research, and existing local representation on ACI Palliative Care Executive Network and Palliative Care NSW Executive Committee.<br><br>As described above, Stage 1 of the project will collaborate with Western NSW Health Intelligence Unit, (HIU), eHealth NSW, and the Australian Digital Health Agency, as well as Business Analyst, Information and Communication Technology, and Web Design contractors to ensure that the IT deliverables that are produced as a result of this project are able to interface with Health eNet (NSW State) and My Health Record (National).<br><br>WNSWPHN is one of seven PHNs selected as a Choosing Wisely Implementation Champion for the Choosing Wisely Australia and Consumers Health Forum of Australia Collaborative Project: Consumer Engagement and Activation Project to support health literacy, patient engagement and health pathways. The PHN will work with an Expert Working Group to ensure the ePAF integrates with existing programs and activities that increase the efficiency and effectiveness of services and improve coordination of care.<br><br>Governance arrangements has been addressed in this AWP Description of Activity. |
| Timeline | **Stage 1**<br>**(April to June 2018):** Business Analyst (BA) contractor<br>**(June 2018 to June 2019):** Information and Communication Technology (ICT) contractor<br>**(July 2018 to June 2020):** Recruit a Palliative Approach Project Coordinator (PAPC) 0.2 FTE<br>**(July to Sept 2018)** Engage a contracted web developer to upload the FWPAF and associated clinical and educational tools onto the WNSW PHN website to be a resource for GPs and clinicians in all other care settings to access to support the ePAF shared care record.<br>**(Oct to Dec 2018)** PAPC works with the WNSW PHN Practice Support Team to undertake the change management processes required to implement and evaluate the web-based FWPAF resource in preparation for the implantation of the ePAF shared health and advance care record.<br><br>**Stage 2**<br>**(July 2019 to Jun 2020):**<br>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:<br>• One General Practice and one MPS in FWLHD<br>• Two RACFs in WNSWLHD.<br><br>Project Timeline - refer to page 17. |

## EMU: the End of life Minimum Universal clinical quality and outcomes reporting tool

(Unpublished: Saurman, Hutchinson and Wenham 2016)




| THE END-OF-LIFE MINIMUM UNIVERSAL TOOL (EMU) – AN AUDITING, REPORTING, AND BENCHMARKING OUTCOME TOOL FOR ALL PEOLC PATIENTS, IN ALL CARE SETTINGS | | |
|---|---|---|
| **AIMS OF A PALLIATIVE APPROACH TO CARE** | **QUALITY AND OUTCOME INDICATORS** | **RECOMMENDED CLINICAL TOOLS** |
| **Improve earlier identification** (ACI EC 4)<br>↑ identification of patients in their last year of life<br>↑ identification of palliative care phase<br>↑ identification in earlier palliative care phase | N/% patients with documented life-limiting diagnosis (eg. metastatic cancer, end-stage chronic disease, etc)<br>N/% patients with documented palliative phases<br>N (days) from diagnosis to death<br>N (days) from initiation of palliative approach to death | • Palliative Care Phase<br>• Surprise Question<br>• Supportive and Palliative Care Indicators Tool (SPICT)<br>• Amber Care Bundle [CEC] |
| **Improve advance care planning** (ACI EC 2)<br>↑ documentation of patient wishes<br>↑ documentation of person responsible<br>↑ documentation of preferred place of care<br>↑ documentation of preferred place of death | N/% patients with documented advance care directive and/or advance care plan<br>N/% patients with documented resuscitation plan<br>N/% patients with documented person responsible<br>N/% patients with documented preferred place of care<br>N/% patients with documented preferred place of death | • Advance Care Directive<br>• Advance Care Plan [FWLHD]<br>• Resuscitation Plan [NSW Health] |
| **Improve coordination of care** (ACI EC 6&7)<br>↑ coordination of care<br>↑ communication between healthcare professionals | N/% patients with documented MDT Case Conference<br>N/% patients referred to specialist palliative care | • Palliative Approach Checklist [FWLHD]<br>• Multi-Disciplinary Team Case Conference [FWLHD] |
| **Improve quality of care** (ACI EC 5&7)<br>↑ holistic assessment of patient needs<br>↑ care provided in accordance with assessed need<br>↑ care provided with adherence to patient wishes<br>↑ care provided in place of patient choosing | N/% patients with documented needs assessment<br>N/% patients with documented care plan<br>N/% patients with documented reduction of distress<br>N/% patients receiving care in preferred place<br>N/% patients with capacity involved in decision making<br>N/% patients without capacity whose person responsible was involved in decision making | • Australian-modified Karnofsky Performance Scale (AKPS)<br>• Resource Utilisation Group-Activities of Daily Living (RUG-ADL)<br>• Palliative Care Problem Severity Score (PCPSS)<br>• Symptom Assessment Score (SAS)<br>• Needs Assessment Tool-Progressive Disease (NAT:PD) |
| **Improve care in last days of life** (ACI EC 8)<br>↓ non-essential treatments in terminal phase<br>↑ essential care in last days of life<br>↑ deaths in place of patient choosing | N/% patients diagnosed as dying (in terminal phase)<br>N/% patients receiving non-essential treatments (eg. observations, investigations, life-prolonging care)<br>N/% patients receiving essential care in last days of life<br>N/% patients prescribed anticipatory medications<br>N/% patients died in preferred place | • Last days of life toolkit [CEC]<br>• RACF End of life pathway [RACF]<br>• Medical Certificate of Cause of Death [NSW]<br>• Death Screen [CEC] |
| **Improve family/carer support** (ACI EC 5&7)<br>↑ assessment of family/carer needs<br>↑ support provided in accordance with assessed need | N/% family/carers with documented needs assessment<br>N/% family/carers receiving support<br>N/% family/carers with documented reduction in distress | • NAT:PD<br>• Carer Support Needs Assessment Tool (CSNAT) |
| **Improve bereavement support** (ACI EC 9)<br>↑ bereavement support | N/% family/carers receiving bereavement support<br>N/% family/carers identified 'at risk' of complex bereavement | • NAT:PD<br>• CSNAT<br>• Core Bereavement Index (CBI) |
| Agency of Clinical Innovation Palliative Care Blueprint Essential Components (ACI EC); Number (N); Clinical Excellence Commission (CEC); Far West Local Health District (FWLHD); Residential Aged Care Facility (RACF); Unique source in brackets | | |

*EMU: End of Life Universal Minimum Tool*
*(Version 1.0 2016)*

## Project Timeline

| IMPLEMENTATION TIMELINE FOR WESTERN NSW PHN SHARE PROJECT (Funded by the GREATER CHOICE FOR AT HOME PALLIATIVE CARE (GCfAHPC) MEASURE) (version 2.0, February 2018) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PRE GCfAHPC | Financial Year 2017/18 | | Financial Year 2018/2019 | | | | Financial Year 2019/2020 | | | | POST GCfAHPC |
| | | Jan-Mar 2018 | Apr-Jun 2018 | Jul-Sept 2018 | Oct-Dec 2018 | Jan-Mar 2019 | Apr-Jun 2019 | Jul-Sept 2019 | Oct-Dec 2019 | Jan-Mar 2020 | Apr-Jun 2020 | |
| **PLANNING, DEVELOPMENT, IMPLEMENTATION & SUSTAINABILITY ACTIVITY TIMELINE** | | | | | | | | | | | | |
| SHARE Project Activity | EOI Funding Submission | Work Plan Submission | Stage 1a: Business Analysis to map and scope FWPAF and ePAF | Stage 1b: Development and implementation of FWPAF resource website<br>Stage 1c: Development and testing of ePAF shared health and advance care record | | | | Stage 2: Implementation of ePAF shared health and advance care record at 4 pilot sites within 2 LHDs | | | | FWPAF and ePAF implementation throughout PHN and beyond |
| GCfAHPC Funded Position/s | | | Business Analyst (BA) Contractor (1.0FTE for 3mths) | Palliative Approach Project Coordinator (PAPC) (0.2FTE for 24 months)<br>Web Design (WD) Contractor (1.0FTE for 3mths)<br>Information and Communication Technology (ICT) Contractor (1.0FTE for 12 months) | | | | Palliative Approach Liaison Officers (PALO) (2.0FTE for 12 months) | | | | |
| WNSW PHN | Engagement of partnership LHDs | Engagement of partner IT organisations<br>Recruitment of BA Contractor | Recruitment of PAPC, WD Contractor, & ICT Contractor | | PHN PSO and DHO to provide in kind support to assist implementation of FWPAF Resource Website | | Recruitment of PALOs | PHN Practice Support Officers (PSO) and Digital Health Officers (DHO) to provide in kind support to assist implementation of ePAF in pilot sites | | | | PHN and LHDs to continue partnership in order to implement FWPAF and ePAF throughout PHN and beyond |
| FW & WNSW LHDs | | Identification of pilot sites | | | LHD SPCT to provide in kind support to assist implementation of FWPAF Resource Website | | LHD Specialist Palliative Care Team (SPCT) to provide in kind support to assist implementation of ePAF in pilot sites | | | | | |
| FWPAF Resource Website | | | | Development:<br>- Development and testing of webbased FWPAF resource (WD contractor) | Planning:<br>- Engagement with local stakeholders (PAPC with PHN PSOs and DHOs)<br>- Baseline clinician surveys (PAPC) | Implementation:<br>-Implement webbased FWPAF resource across PHN (PAPC with PHN PSOs and DHOs) | Evaluation & Sustainability:<br>- Develop and implement local sustainability activities<br>- Mid-project clinican surveys (PAPC) | - Ongoing local sustainability activities | | | | |
| ePAF Shared Health Record | | | ePAF Scoping:<br>- Mapping, Gap Analysis and Scoping of ePAF (BA contractor) | ePAF Development:<br>- Development of ePAF (ICT contractor) | | ePAF Testing:<br>- Testing of ePAF (ICT contractor) | Pilot Planning:<br>- Engagement with local stakeholders (PAPC)<br>- Identify site palliative approach coordinators<br>- Assess pilot site education and training needs with mid-project clinician surveys (PAPC) | Pilot Implementation:<br>- Baseline clinical audits (PAPC & PALOs)<br>- Implement local PAF/ePAF clinical framework and associated policy documents (PALO)<br>- Implement formal education and training and informal mentoring (PALO)<br>- On site clinical presence of PALO and SPCT mentors | - Ongoing formal education and training and informal mentoring (PALO)<br>- On site clinical presence of PALO and SPCT mentors | Pilot Evaluation & Sustainability:<br>- Develop and implement local sustainability activities<br>- Project end clinical audits (PAPC & PALOs)<br>- Project end clinician surveys (PAPC & PALOs) | - Ongoing local sustainability activities | |
| **REPORTING TIMELINE** | | | | | | | | | | | | |
| Research and Governance Activities | Develop EOI Funding submission | Develop Activity Work Plan & Baseline report | 3 month report: inc BA report | 6 month report | 9 month report | 12 month report: inc WD report | 15 month report: inc ICT report | 18 month report | 21 month report | 24 month report | 27 month report | Final Report, Presentations & Publications |

WNSWPHN – Western New South Wales Primary Health Network; FWLHD – Far West Local Health District; WNSWLHD – Western New South Wales Local Health District; FWPAF – Far West Palliative Approach Framework; ePAF – electronic Palliative Approach Framework; BA – Business Analyst; WD – Web Design; ICT - Information & Communication Technology; PAPC – Palliative Approach Project Coordinator; PSO – Practice Support Officer; DHO - Digital Health Officer; PALO – Palliative Approach Liaison Officer SPCT – Specialist Palliative Care Team