Department of Human Services

Palliative Care Service Delivery Framework & Funding Model

Outline of Service Delivery Model

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This report presents an ***outline*** of the proposed Service Delivery Framework (SDF). It provides a succinct overview of the proposed SDF without explanation as to how or why the various components of the SDF have been framed.

This report should be read in conjunction with the full (draft) Service Delivery Framework. Other supporting documents include the Literature Review, Service Mapping Report, and Consultation Feedback Report.

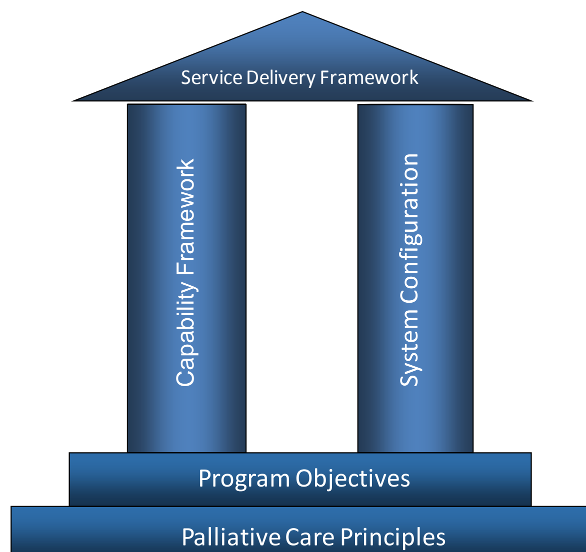
Structure of the Service Delivery Framework

The intention of the SDF is to provide a common/consistent basis for the provision of palliative care across the state. Therefore, consideration has been given to the many facets of palliative care that would enable a comprehensive Framework to be developed.

All of the facets can be distilled into three main components (or building blocks). They are:

1. **Principles and program objectives** that underpin the SDF.
2. **A Capability Framework** which delineates the roles, levels of capacity/capability that can be expected from a service provider, and includes Access Expectations for each of the main types of palliative care services. It also discusses important dimensions of the capability framework including service models, workforce availability, education & training, research, a quality framework and infrastructure.
3. **System configuration** for the Framework identifies how the service system might be organised or structured. It also includes consideration of processes and approaches to service integration.

Schematic representation of the SDF building blocks



Principles

The principles are:

Principle 1: *"People with a life-threatening illness and their carers and families have information about options for their future care and are actively involved in those decisions in the way that they wish."*

Principle 2: *"Carers of people with a life-threatening illness are supported by health and community care providers."*

Principle 3: *"People with a life-threatening illness and their carers and families have care that is underpinned by the palliative approach."*

Principle 4: *"People with a life-threatening illness and their carers and families have access to specialist palliative care services when required."*

Principle 5: *"People with a life-threatening illness and their carers and families have treatment and care that is coordinated and integrated across all settings."*

Principle 6: *"People with a life-threatening illness and their carers and families have access to quality services and skilled staff to meet their needs."*

Principle 7: *"People with a life-threatening illness and their carers and families are supported by their communities."*

Program objectives

The program objectives are intended to identify expected outcomes for palliative care service system. They are:

1. Access

- Patients receive palliative care services on a needs basis with the most urgent cases receiving priority.
- Patients receive palliative care services as close as possible to where they live.
- A population-based approach to planning and resource distribution.
- Recognition/accommodation of the particular needs of different groups of patients requiring palliative care (such as children, those with degenerative neurological conditions, aged persons, Aboriginal and Torres Strait Islanders and Culturally And Linguistically Diverse patients).
- A health care workforce that is informed and aware of the nature and availability of specialist palliative care, advice and support.

2. Acceptability (client/carer focus)

- Service delivery that meets the individual needs of patients and carers.
- Information available to patients/carers to enable informed decisions.

- Education of the community with regard to end of life care.
- Active support for carers.

3. Appropriateness

- Patients receive palliative care services in the most appropriate setting consistent with safe clinical practice.
- A service system that incorporates generalist and specialist palliative care providers.

4. Continuity

- Integrated care that is supported by clarity of roles and responsibilities among health providers regarding the provision of palliative care.
- There is collaboration that is supported by structures, processes and protocols.

5. Effectiveness

- A comprehensive service that has all of the elements that can reasonably be expected to deliver holistic care.
- Timely referral to palliative care.
- Care is delivered by an inter-disciplinary team at the point of assessment and along the care pathway.
- An efficient system where the configuration of services minimises duplication of roles and resources, including triage, assessment and service delivery.
- An available and skilled workforce.
- Leadership within the sector and at regional and local service levels.

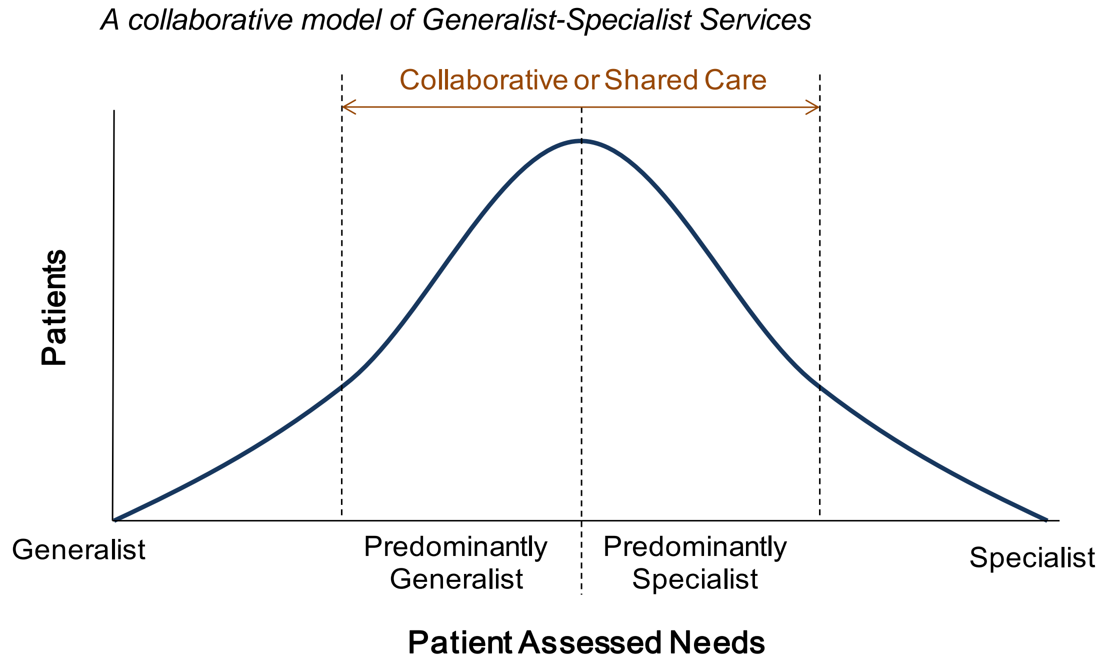
6. Safety

- To deliver formal and informal specialist palliative care education and training for health care professionals
- To support improved models of care, service delivery systems and efficient service delivery through evidence based research.

Ensuring sustainable palliative care service delivery The proposed model is a collaborative approach between generalist health care providers and specialist palliative care services that promotes appropriate care based on the needs of the patient and their family. The sustainable palliative care service model is illustrated in the following Figure. It is expected that this model will be utilised to guide service delivery in all palliative care settings and across all levels of care. This collaborative model takes into account the nature of palliative care which requires a service response that incorporates linkages with generalist health care services, negotiation of shared care collaborative arrangements, including consultancy advice, and the

delivery of direct specialist palliative care based on the assessed needs of the patient and their family.

A collaborative model of Generalist-Specialist Services



Capability framework

Eligibility and access to services in the preferred SDF would be:

- Needs based
- Access is determined by each (local) service provider based on centrally determined eligibility guidelines. The centrally determined eligibility guidelines would be the responsibility of the Department of Human Services in consultation with the sector
- The level of demand and complexity of patients/carers is monitored in order to support and understand service level activity and demand, and inform developments at the system wide level.

The core services for palliative care are:

- Inpatients, specialist community based services, consultancy services and statewide services;
- Delivered within an interdisciplinary framework and are dependent on the level detailed in the Capability Framework. It is expected that if comprehensive interdisciplinary skills are not available within a service level that there are formal protocols that clearly describe access and referral arrangements.

The draft **Capability Framework** articulates service delivery expectations for the three key palliative care service settings. These settings are:

1. Inpatient palliative care services

2. Community palliative care services

3. Consultancy palliative care services (Are defined as either hospital based or community based).

4. Statewide services

Within each of these settings, the capability framework identifies:

- Three levels of inpatient palliative care services,
- Two levels of community palliative care services and:
- One level of consultancy palliative care services.
- One level of statewide services

For each level the capability framework describes seven dimensions of measuring/describing capability.

Access expectations.

Access expectations identify the geographical scope of each level for each service setting. Access expectations take into account the metropolitan and regional service characteristics. These are detailed below.

For inpatient services, the proposed service expectations are:

❖ In metropolitan regions there should be at least one Level 3 inpatient palliative care service. There should be an effective distribution of Level 2 inpatient palliative care services to meet the needs of sub-regional populations, taking into account the location of services in neighbouring metropolitan and rural regions.

❖ In rural regions there should be at least one Level 2 inpatient palliative care service (with an expectation that this could be progressively developed to a Level 3 service over time). There should be an effective distribution of Level 1 inpatient palliative care services to meet the needs of sub-regional populations, taking into account the location of services in neighbouring rural and any neighbouring metropolitan regions.

For specialist community palliative care, the service expectation is:

❖ In metropolitan and rural regions there should be at least one Level 2 community palliative care service. This should have responsibility for ensuring that all relevant patients in the region, including at a sub-regional level, have access to community palliative care services. This can occur through direct provision by a Level 2 community palliative care service or through collaboration and agreements with Level 1 community palliative care services at a local and sub-regional level.

For consultancy, the service expectation is:

- In metropolitan and rural regions there should be at least one consultancy team palliative care service. This should be formally linked to all inpatient and community palliative care services in the region.

The draft capability statements are provided below.

A uniform or statewide assessment and ranking of capability levels for each service provider will be determined by the Department of Human Services in consultation with regional palliative care consortia, and external experts if required.

	Inpatient Palliative Care Services - Level 3
Role description and range of services	▪ Provides comprehensive care and has capacity to manage the full range of clients including clinically and/or psychosocially complex ▪ Assessment of patient medical care needs and exploration of patient goals, expectations and choices for place of care ▪ Complex symptom and pain management including complex intravenous and intrathecal medication ▪ Psychological, emotional and spiritual support for patients, carers and families (through trained and volunteer staff) ▪ Access to pastoral care, bereavement support, respite care, volunteer services, liaison psychiatry and psycho-oncology services ▪ Discharge planning inclusive of interdisciplinary assessment, liaison with community-based service providers, and provision of discharge information to primary care providers ▪ After hours on-call provision for specialist palliative care advice and patient support
Catchment	▪ Regional (and potentially statewide role for some services)
Staffing profile	▪ Multidisciplinary team including medical practitioner with specialist qualifications in palliative medicine (Australasian Chapter of Palliative Medicine), specialist nursing and allied health staff with qualifications and experience in palliative care, social work/psychologist, specialist pharmacist, pastoral care staff, complementary and diversionary therapy staff ▪ Provision of on-call or other after-hours support of medical staff with experience in palliative care ▪ Volunteer Coordinator (either specific to palliative care or through hospital-wide volunteer program)
Education, training and research	▪ Undergraduate and postgraduate teaching (registrars, trainees, students) ▪ Formal education programs in the palliative care approach available to other staff and on an outreach basis to external health professionals ▪ Education programs for patients, carers and families ▪ Staff with joint appointments with universities ▪ Active participation and leadership in palliative care research
Quality framework	▪ Meets requirements for RACP accreditation in relation to palliative medicine ▪ Participates in PCA's National Standards Assessment Program ▪ Contributes data to a system that monitors & measures palliative care outcomes ▪ Use of validated assessment tools and evidence-based care pathways and protocols ▪ Patient satisfaction, carer and family feedback and other mechanisms to support consumer responsiveness ▪ Quality improvement and assurance processes including monitoring of clinical indicators and incident reporting
Service integration and linkages	▪ Protocols and liaison with other services and clinical support units within the hospital (including medical and surgical acute wards, sub-acute care, emergency departments, medical and radiation oncology, ICU, diagnostic imaging)

	▪ Leadership in service and care coordination through mechanisms such as interdisciplinary team meetings and case conferencing involving providers across settings ▪ Formal link with a palliative care consultancy team ▪ Formal links with statewide palliative care services ▪ Formal links with community palliative care services to enable integrated and coordinated care for patients ▪ Active participation in networking arrangements through the regional palliative care consortia
Infrastructure, facilities and supporting services	▪ Access to designated palliative care beds ▪ Accommodation and other support services for families and carers ▪ Telemedicine facilities ▪ Equipment loan and other services to support return to home for patients

Inpatient Palliative Care Services - Level 2	
Role description and range of services	▪ Provides a broad spectrum of care, catering for most palliative care patients including physical and psychosocial needs ▪ Assessment of patient medical care needs and exploration of patient goals, expectations and choices for place of care ▪ Provides or facilitates access to pastoral care, bereavement support and respite care ▪ Discharge planning and effective liaison with community-based palliative and generalist providers
Catchment	▪ Sub-regional
Staffing profile	▪ Interdisciplinary team ▪ Substantial presence/involvement of medical practitioner with specialist qualifications in palliative medicine who may work across other health services ▪ Provision of on-call or other after-hours support of medical staff with experience in palliative care ▪ Nursing staff with experience in palliative care ▪ Access to allied health and staff supporting psychosocial needs of patients, carers and families ▪ Volunteer Coordinator (either specific to palliative care or through hospital-wide volunteer program)
Education, training and research	▪ Undergraduate and postgraduate teaching (registrars, trainees, students) ▪ Provide education and support on the palliative approach within the health service ▪ Some outreach education and support to generalist and community based services ▪ Provide education and support for patients, carers and families ▪ Some participation in palliative care research and quality improvement projects
Quality framework	▪ Participates, or undertakes self-assessment, against PCA's National Standards Assessment Program ▪ Contributes data to a system that monitors & measures palliative care outcomes ▪ Use of validated assessment tools and evidence-based care pathways and protocols ▪ Participates in health service system wide quality assurance activities (including patient satisfaction, clinical indicator monitoring)
Service integration and linkages	▪ Protocols and liaison with other services and clinical support units within the hospital ▪ Formal link with a palliative care consultancy team ▪ Relationship and information sharing with statewide palliative care services ▪ Agreements and links with community palliative care services ▪ Participation and involvement in coordination activities through the palliative care consortia
Infrastructure, facilities and supporting services	▪ Access to designated palliative care beds and/or inpatient beds ▪ Telemedicine facilities ▪ Equipment loan and other services to support return to home for patients

Inpatient Palliative Care Services - Level 1	
Role description and range of services	▪ Provides management of stable patients with generally anticipated problems and outcomes ▪ Physical and psychosocial care to patients needing palliative care ▪ Discharge planning and effective liaison with community-based palliative and generalist providers ▪ Provides or facilitates access to pastoral care, bereavement support and respite care
Catchment	▪ Local and sub-regional
Staffing profile	▪ Nursing staff with knowledge of palliative care approach and/or qualifications in palliative care ▪ Medical practitioner, with support/access to palliative medicine specialists through consultancy teams, protocols with Level 2 & 3 inpatient services or other arrangements to provide advice and referral for more complex patients ▪ Volunteer Coordinator (either specific to palliative care or through hospital-wide volunteer program)
Education, training and research	▪ Information to other staff on the palliative approach ▪ Support and education for patients, carers and families
Quality framework	▪ Self-assessment against PCA's National Standards Assessment Program ▪ Quality activities are supported through formal links with Level 2 & 3 inpatient services and the palliative care consortia
Service integration and linkages	▪ Has referrals and protocols to organise access to bereavement support and respite for patients, carers and families ▪ Links and referral arrangements to Level 2 & 3 inpatient palliative care services ▪ Links and information sharing with community palliative care services ▪ Understanding of services offered by statewide palliative care services ▪ Participation and involvement in coordination activities through the palliative care consortia
Infrastructure, facilities and supporting services	▪ Access to inpatient beds ▪ Telemedicine facilities

Community Palliative Care Services - Level 2	
Role description and range of services	▪ Provides comprehensive clinical care (including symptom and pain management) and psychosocial support for patients able to be supported in the community ▪ Arrangements for 24 hour coverage to meet needs of community patients and their families and carers ▪ Experience and provision of advanced care planning and end of life care with clear protocols for referral to inpatient services ▪ Assessment of patient medical care needs and exploration of patient goals, expectations and choices for place of care ▪ Provides or organises access to respite care ▪ Provides or organises access to bereavement support ▪ Volunteer program
Catchment	▪ Sub-regional and regional
Staffing profile	▪ Inter-disciplinary team approach ▪ Senior nursing staff with specialist qualifications and experience in palliative care and/or nurse practitioner in palliative care, working collaboratively (including shared care arrangements) with palliative care physicians and/or other medical practitioners (including GPs, other generalist and specialist medical practitioners) ▪ Allied health and psychosocial support staff (including psychological, social and spiritual support) as integral components of the inter-disciplinary team ▪ Volunteer Coordinator
Education, training and	▪ Teaching and training for nursing, medical staff and primary care staff in the palliative

research	approach ▪ Education programs for patients, carers and families ▪ Participation in palliative care research and quality improvement activities
Quality framework	▪ Participates, or undertakes self-assessment, against PCA's National Standards Assessment Program ▪ Contributes data to a monitoring & measurement system of palliative care outcomes ▪ Range of quality assurance processes (clinical indicator and incident monitoring) ▪ Use of evidence-based care pathways and protocols ▪ Patient satisfaction, carer and family feedback and other mechanisms to support consumer responsiveness
Service integration and linkages	▪ Collaborative relationships with generalist and specialist health providers to support joint management and shared care of patients in the community ▪ Formal link with a palliative care consultancy team ▪ Formal links with inpatient and statewide palliative care services ▪ Participation in networking arrangements through the regional palliative care consortia
Infrastructure, facilities and supporting services	▪ Access to inpatient beds and respite facilities ▪ Telemedicine facilities ▪ Equipment loan and other services to support patients at home

Community Palliative Care Services - Level 1	
Role description and range of services	▪ Provides one or more specific services (not full range of comprehensive care) to support patients in the community ▪ Range of services may include: physical care including symptom and pain management, psychosocial care, bereavement support, respite care ▪ Knowledge of advanced care planning and end of life issues ▪ Is able to provide, or link patient into a volunteer program
Catchment	▪ Local and sub-regional
Staffing profile	▪ Nursing staff and/or allied health staff with experience in palliative care ▪ May involve generalist medical staff and/or nurse practitioner in palliative care
Education, training and research	▪ Provides general information and education for patients, carers and families on palliative care issues
Quality framework	▪ Quality assurance processes (clinical indicators) ▪ Patient satisfaction, carer and family feedback and other mechanisms to support consumer responsiveness
Service integration and linkages	▪ Collaborative relationships with generalist and specialist health providers to support joint management and shared care of patients in the community ▪ Is linked to a Community Palliative Care Level 2 service ▪ Understanding of services offered by statewide palliative care services ▪ Participation and involvement in coordination activities through the palliative care consortia
Infrastructure, facilities and supporting services	▪ Telemedicine facilities ▪ Equipment loan and other services to support patients at home

Consultancy Team Palliative Care Services	
Role description and range of services	▪ 'In-reach' consultancy advice and support to hospital-based staff ▪ 'Outreach' consultancy advice and support to generalist community-based health care professionals and community palliative care services ▪ Assessment and symptom management, clinical decision-making, advanced care planning, patient and family communication, end of life care ▪ Coordinating access and service provision for patients, carers and their families through referral and liaison with inpatient palliative care units, outpatient clinics and

	community palliative care services ▪ Capacity building, education and advocacy on the palliative approach
Catchment	▪ Regional and sub-regional
Staffing profile	▪ Interdisciplinary team including medical practitioner with specialist qualifications in palliative medicine, and nursing staff with qualifications and experience in palliative care. May include a nurse practitioner in palliative care ▪ Facilitates access to other required services including allied health, psychosocial support and pastoral care
Education, training and research	▪ Undergraduate and postgraduate training of nursing and medical staff ▪ Extensive role in provision of education about palliative care for health professionals across all settings and on a regional and community basis ▪ Staff with joint appointments with universities ▪ Participation in palliative care research
Quality framework	▪ Participates in PCA's National Standards Assessment Program ▪ Contributes data to a system that monitors & measures palliative care outcomes ▪ Use of validated assessment tools and evidence-based care pathways and protocols
Service integration and linkages	▪ Collaborative relationships with generalist and specialist health providers to support joint management and shared care of patients requiring a palliative approach ▪ Leadership role in standardising referral protocols and communication channels with other health providers to support improved access to palliative care services on a geographic basis ▪ Formal links with statewide palliative care services ▪ Formal links with inpatient and community palliative care services to enable integrated and coordinated care for patients ▪ Active participation in networking arrangements through the regional palliative care consortia
Infrastructure, facilities and supporting services	▪ Access to inpatient beds ▪ Telemedicine facilities
	▪
Statewide Services	
Role description and range of services	▪ Consultancy advice and support to palliative care services ▪ Consultancy advice and support to generalist health care providers ▪ Coordinating access and service provision for patients, carers and their families through referral and liaison with palliative and other health care providers ▪ Capacity building, education and advocacy
Catchment	▪ Statewide
Staffing profile	▪ Interdisciplinary care according to specific service profile ▪ Facilitates access to other required services
Education, training and research	▪ May provide undergraduate and postgraduate training ▪ Extensive role in provision of education about specific care needs for service cohort for palliative care providers across all settings ▪ May include staff with joint appointments with universities ▪ Participation in palliative care research
Quality framework	▪ Participates in PCA's National Standards Assessment Program ▪ Contributes data to a system that monitors & measures palliative care outcomes ▪ Use of validated assessment tools and evidence-based care pathways and protocols
Service integration and linkages	▪ Collaborative relationships with generalist and specialist health providers to support joint management and shared care of patients ▪ Leadership role in standardising referral protocols and communication channels with palliative care services ▪ Formal links with inpatient and community palliative care services to enable integrated and coordinated care for patients ▪ Active participation in networking arrangements through the regional palliative care

		consortia and other statewide services
Infrastructure, facilities and supporting services	▪	Access to Telehealth facilities

Workforce availability. This draft SDF proposes several approaches, where each level of the service system plays an important part:

- Service providers must continue to take responsibility for the adequacy and availability of the palliative workforce consistent with their role and capability.
- Each region/consortia should be responsible for identifying regional shortfalls in palliative care workforce and developing specific strategies to address these shortcomings through:
  - Specific training and workforce recruitment & retention strategies;
  - Collaborative joint appointments between service providers; and
  - Contributing to a statewide workforce development approach.
- A sector-wide organisation (in conjunction with DHS) should be responsible for the statewide planning of a palliative care workforce with respect to overall workforce numbers, location and professional mix.

Teaching & training. There should be a progressive and planned move toward a national-level phase in of expected (possibly mandatory) palliative care training (and accreditation) for health professions operating in *specialist* palliative care services.

This would be supported by voluntary palliative care training for generalist health professionals.

Research. It is proposed to encourage research in palliative care by service providers, statewide entities and academic institutions, consistent with the articulated directions and priorities of the palliative care sector. This includes innovative evidence-based service delivery models.

Quality & risk management. There are three main areas of focus:

- *Accreditation* consistent with appropriate national standards (e.g. Palliative Care Australia Standards)
- *Practice guidelines*. Develop/adopt evidence-based practice guidelines. These may include protocols developed through other key projects (e.g. Evaluation and Refresh of the Strengthening Palliative Care Policy; the Centre for Palliative Care Education and Research for the Victorian Nurse Practitioner Project), or defined within the DHS Clinical Service Improvement project.
- *Quality improvement* activities. These could include a range of quality improvement activities identified through the DHS Clinical Service Improvement project and other key quality initiatives e.g. NSAP. All activities will be underpinned by an evidence base.

Performance monitoring & accountability. Will identify measures that support monitoring and service delivery and informs system wide benchmarking and performance comparisons. It is proposed to progressively develop a performance monitoring regime that reflects expected service outcomes (KPIs) across:

- Activity in all major service streams;
- Financial performance;
- Efficiency;
- Workforce capacity; and
- Quality improvement.

At a regional and system-wide level it would also incorporate KPIs that include all of the above, indicate 'equity of access', and provide sector benchmarking and performance comparisons.

It is proposed that performance monitoring be based on a common set of statewide KPIs, developed by DHS, with input from the sector.

ICT.

It is proposed that there is a Department of Human Services directed role that:

- Promote compatibility between IT systems of different service providers; and
- Promote a common approach and the use of standardised minimum data sets. There was also recognition that regions may collect supplementary data above the minimum, if required.

System configuration

Service planning. It is proposed that planning for palliative care be undertaken by the Department of Human Services. This is also consistent with the application of the Capability Framework.

Service purchasing. It is proposed that the purchasing role be undertaken by DHS in preference to the purchasing role being transferred to another entity.

A structure for collaboration and coordination. There were benefits and shortcomings for each option considered. No one option was clearly superior. Choosing the most appropriate structure needs to be made 'on balance', weighing the relative strength of argument.

It is proposed that the structure that best supports collaboration and coordination is based on a _super-regional model_ (i.e. combining more than one of the existing consortia) that has a governance arrangement based on an unincorporated entity with a MoU with enforceable provisions that encourage service providers to meet the charter of the MoU.

A process for collaboration and coordination. It is proposed to develop/entrench a range of processes and protocols to support collaboration and service integration, including:

- Collaboration agreements (MoUs);
- Communication protocols, including written referrals on a standard format;
- Formal intake processes;
- A structured (inter-disciplinary) assessment process including a common assessment tool;
- A validated measure of patient complexity; and
- A patient prioritisation process.

In addition, there are a range of identified workforce initiatives that can also support collaboration and coordination, including joint senior staff appointments, active fostering of a collaborative culture and inter-dependent activities and services.

Patient flow and integration. It is proposed that processes for referral, intake, assessment and planning are to be common and consistent across the state and that patient flow processes are:

- Formal and coordinated between service providers; and are
- Overseen/monitored by the consortia.

Flexibility & responsiveness. It is proposed to ensure that genuine flexibility and responsiveness is built into the SDF through:

- Enhanced after-hours services on a sustainable basis;
- Tailored care to meet patient/carer's holistic needs;
- The monitoring of instances where care varies from the preferred services of the patient; and
- The monitoring of waiting times based on consistent definitions.

It is proposed that this be developed as a common and system-wide set of components that embed responsiveness.

Support for carers. It is proposed to:

- Improve access to respite care;
- Enhance grief & bereavement support;
- Improve education and information for carers; and
- Psychosocial support.

Leadership. It is proposed to develop leadership at local, regional and state level.

Statewide level – This may potentially include activities such as proactive community education in the palliative care approach, lead the reduction of clinical variation in care across the state, sponsor national research, develop greater awareness amongst clinicians of appropriate and early referral, amongst others;

Regional level – This may potentially include activities such as the development of a sustainable regional workforce (including NSAP), workforce credentialing, and consistent models of care etc.

Local level – This may potentially include promoting a palliative care approach within a health care provider, building/strengthening local links, and raising community awareness of palliative care etc.

Consultation feedback

The next phase of the Service Delivery Framework project is to discuss and receive feedback on this draft document from the palliative care sector. Written submissions can also be sent to:

Draft SDF Feedback
Aspex Consulting
Clarendon Terrace
212 Clarendon St
East Melbourne 3002

Or, alice.miller@aspexconsulting.com.au