

**WCMICS Funding Program 2014/15
FINAL REPORT**

1. Project Details	
Project Title:	Improving General Practitioner Integration in Cancer Supportive Care in Advanced Disease
Tumour Stream:	All
Hospitals involved:	Royal Melbourne Hospital, St Vincent's Hospital, Peter MacCallum Cancer Centre
Date of Interim Report:	October 2015
Project Start Date:	April 2015
Completion Date:	April 2016
Project Managers:	Fiona McCormack and Sita Vij
Project Sponsor(s):	A/Prof Brian Le

2. Abstract

Most patients want to receive care at home, particularly those with advanced cancer and those receiving end-of-life care. This often requires re-engagement with general practitioners (GPs) who may have had little involvement during cancer treatment (e.g. surgery and chemotherapy). Furthermore, GPs may have little experience with providing cancer supportive and palliative care, and may have had little interaction with palliative care services. Another challenge is that patients frequently move between hospital and home and across regions where they are cared for by different hospital and community-based palliative care providers. This leads to fragmented, often poorly coordinated care, which could be greatly improved by an engaged, upskilled GP.

Preliminary findings from the WCMICS GP Communication Project (August 2014) highlighted the often unrecognised, important role that GPs have in cancer care. This project focused on communication regarding chemotherapy treatments, and found that all surveyed patients had a routine GP, and that more than 50% of patients consulted their GP many times or routinely during cancer treatment, often regarding chemotherapy.

In what remains the largest and most cited study of the factors of importance to patients and families at end-of-life, Steinhauser¹ identified key tasks where GPs implicitly can and should lead care. This includes the areas of pain and symptom management in the community setting, decisions about treatment preferences (and advance care planning), being treated as a "whole person", and preparation for death. GPs are well placed to facilitate management of these factors as they often have the best relationships with patients and their families compared to other health care providers. This project looked at the extent to which GPs are trained and capable of managing palliative and supportive care issues for patients with advanced disease. It also explored GPs' perceptions of their

¹ Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors Considered Important at the End of Life by Patients, Family, Physicians, and Other Care Providers. JAMA. 2000;284(19):2476-2482.

role and highlighted barriers in delivering supportive and palliative care within the community. The majority of GPs in this survey (82%) reported caring for one or more patients with palliative intent in the recent past. A sizeable minority (30%) of these GPs did not feel confident in providing this care due to patient complexity and inadequate training and resources. Barriers highlighted included poor communication from specialists and hospitals about treatments and care plans and difficulty accessing treatment guidelines. Positive enablers were noted to be involvement of community palliative care services and strong links to hospital-based palliative care teams. These findings were used to develop an education/resource pack for GPs. These resources are available at the point of care on an established health information web platform, HealthPathways Melbourne.

3. Introduction (background, purpose of the project)

The Royal Melbourne Hospital, St Vincent's Hospital and Peter MacCallum Cancer Centre collaborated on a project to improve GP integration in cancer supportive care in advanced disease. The aim of the project was to empower GPs to be actively involved in high-quality care of patients with advanced cancer in conjunction with the hospital oncology and palliative care specialist services and community palliative care services.

4. Methodology

This project included the development of a survey to determine GP needs in caring for palliative care patients with advanced cancer. The survey findings provided the basis for prioritising GP needs in the development of a resource pack for GPs and the development of Palliative care HealthPathways to assist GPs in caring for patients with advanced cancer. A GP resource pack was developed in collaboration with HealthPathways Melbourne.² This forms part of a suite of palliative care pathways that will be online around June 2016. GPs were asked to review the draft HealthPathways site in order to obtain input on the palliative care resource pack.

A workshop for GPs on palliative care was facilitated by the hospitals in collaboration with Melbourne Primary Care Network. Pre and post-workshop questionnaires were administered in order to gauge participants' level of knowledge and understanding of palliative care principles. Participants included GPs from across Victoria, staff from aged care facilities, as well as allied health and nursing staff. The workshop involved the Decision Assist³ palliative care framework, case studies and time for questions in order for GPs to obtain advice from three palliative care physicians who facilitated the sessions.

The project managers also met with the Palliative Care teams at The Royal Melbourne Hospital and St Vincent's Hospital to look at current processes and opportunities for improvement. This included improving correspondence with GPs and looking at new ways of communicating with General Practice to ensure handover of clinical information.

² HealthPathways Melbourne: <https://melbourne.healthpathways.org.au>

³ Decision Assist: <http://www.caresearch.com.au/caresearch/tabid/3206/Default.aspx>

5. Project Activities, Findings, Outcomes (including evidence of achievement)

Specify any information/tools developed and suitable/applicable for sharing across WCMICS

GP 'needs assessment' survey

The initial GP survey (Appendix A) was developed in Survey Monkey in order to obtain information from GPs on providing palliative care to patients in the community. The survey also included questions on HealthPathways to determine the usefulness of developing an online GP resource pack and palliative care pathways. The survey was promoted online via hospital websites, Primary Health Network e-newsletters and targeted promotion to local practices. Paper surveys and a link to the survey were also distributed at local palliative care workshops in order to improve the response rate. Refer to Appendix B for the full GP survey report. There were 56 responses to the survey.

Pre-workshop questionnaire (Appendix C)

A pre-workshop questionnaire was sent to workshop attendees to complete before the event. The aim of this survey was to collect pre-workshop data as a comparison to participants' level of knowledge following the workshop. The questionnaire also allowed the project team to obtain feedback on the draft HealthPathways GP Palliative Care Resource page which was developed as part of the project. Refer to Appendix D for responses to the pre-workshop questionnaire.

Workshop evaluation data

Following the Palliative Care in General Practice Workshop, an evaluation form (Appendix E) was provided to participants for completion. This is a standardised tool provided by Decision Assist as the workshop was based on the Decision Assist Living Longer, Dying Better workshop content. The responses to the evaluation questions are provided in the comparison data – pre and post surveys (Appendix F).

Communication with GPs at St Vincent's

St Vincent's Palliative Care Unit has developed an e-form template to populate a GP letter (Appendix G). This will be completed following a palliative care consultation when the patient is admitted to another unit. The template outlines standardised headings to ensure GPs receive the appropriate information. It also includes a contact person for GPs to obtain advice and support in regard to their patient's care if required. The Palliative Care outpatient team have also readdressed the need for keeping GPs informed following outpatient appointments. Training has been set up with OzeScribe to recommence letter dictation which can also be sent via secure messaging through Argus.

Revising referral pathways and website content

Project managers met with palliative care teams at The Royal Melbourne and St Vincent's Hospitals to discuss the referral process to palliative care. Hospital website content was updated as part of the project to ensure that GPs can access accurate information on how to refer and who to contact within palliative care for advice regarding a patient.

Palliative Care HealthPathways

The HealthPathways team at the Primary Health Networks has initiated the development of a suite of palliative care pathways including information on assessment, management and referral for GPs. The GP resource pack will also be available on this site. Input is being sought from key stakeholders such as Palliative Care Consortia, community palliative care and hospital specialists to ensure the pathways include input from all areas.

The pathways are still in the draft stage and are being reviewed:

GP Palliative Care Resources⁴

Referral to Palliative Care Services⁵

*Palliative Care Pathways are currently being developed in collaboration with key stakeholders – pages include symptom control, terminal phase management, caring for a dying patient at home etc.

*NB: These pages are currently in draft so this content may change.

Project Working Group

The working group met monthly / bi-monthly as required. The group involved project managers, GP Liaison, palliative care physicians from each hospital, community palliative care services, a GP representative, consumer representative and other interested hospitals such as Western Health.

Dissemination plan

The project findings will be disseminated widely to key stakeholders, hospital executives and submission of a paper for publication in a peer-reviewed journal detailing the results of the initial GP survey. The project report will be circulated to relevant stakeholders in order to promote project findings.

Submission of a paper

As part of the project, the project managers are drafting a paper for submission to a peer-reviewed journal. This will detail learnings from the GP needs assessment survey and GP perspectives on providing palliative care within the community.

6. Limitations/Deviations from Project Plan

The revised project plan (Appendix G) states that the GP education session was to be delivered September – December. There were some delays with this workshop due to the holiday period and the education event was therefore postponed to 23 February 2016 to allow more time to promote the event to GPs. This is the only deviation from the project plan. All other activities were undertaken according to the timeline of the project.

7. Consumer Participation Evaluation

How were consumers involved in the project? Which elements of this worked well and which could be improved?

A consumer representative was identified through St Vincent's Cancer Centre Nurse Unit Manager. The consumer representative attended the working group meetings and provided valuable insight for the project. Unfortunately, health issues prevented the consumer representative from attending meetings towards the end of 2015. Valuable consumer insight was still received early on in the project to identify issues and initiate the development of processes and resources. Ideally, another consumer representative would have been appointed but it was difficult to find another representative.

A GP representative also attended the working group meetings along with two hospital GP liaison consultants. This meant that the GP perspective was well represented at the meetings, allowing for insight into barriers and enablers for caring for palliative care patients within the community.

⁴ <http://melbournedraft.healthpathways.org.au/234284.htm>

⁵ <http://melbournedraft.healthpathways.org.au/21093.htm>

8. Evaluation and Recommendations

Include a description of how this project will be sustainable and transferable across other tumour streams and health services.

The purpose of this project was to improve GP integration in cancer supportive care. This requires a high degree of involvement from all care providers, including care provision in the home. In order for the patient to receive adequate care, minimise disruption, maximise quality of life and prevent unnecessary admissions to hospital, the GP is often at the centre of the care continuum providing care either at home or close by in general practice.

Activities involved in home care for palliative care patients include patient assessment, medication management and symptom control including pain management. This should also include clarity around the overall plan of care as well as patient and carer goals. Palliative care at home is a team arrangement with the community palliative care service often providing day to day patient management and feedback to the GP. The GP, as the medical care provider, relies on accurate and clear communication from both the hospital and community palliative care teams in order to make key decisions about the patient's care. Based on the learnings from this project, the project team's recommendations are to:

1. Improve communication between health care providers (hospital, GP, community palliative care services) through timely and appropriate written and verbal communication from both hospital to GP and GP to the hospital. This includes patient letters, discharge summaries and easily accessible contact details for specialists in case GPs need advice on urgent and important management changes
2. Improve access to palliative care information and resources for health professionals with clinically relevant information
3. Further develop a suite of palliative care HealthPathways in conjunction with Eastern and North West Melbourne Primary Health Networks, palliative care clinical working group and the subject matter experts
4. Ensure health professionals have access to continuing professional development in the areas of palliative care and advance care planning

These recommendations can be adopted by other health services looking at implementing a similar project in the area of palliative care. It is integral to foster partnerships between health care providers when coordinating care to improve outcomes for palliative care patients.

Refer to Appendix B (GP Survey Data), Appendix D (Pre-Workshop Survey Responses) and Appendix F (Comparison Data – pre and post-workshop evaluation) for a complete summary of evaluation findings.

9. Implementation

How will new processes/improvements be sustained? Include budgetary considerations.

HealthPathways is an online tool for GPs that provides evidence-based information on the assessment and management of common medical conditions. It also includes referral information for local hospitals and community services. HealthPathways has been implemented across the Northern and Eastern areas of metropolitan Melbourne in a collaborative arrangement with the North West Melbourne Primary Health Network (PHN), Eastern Melbourne PHN, Royal Melbourne Hospital, Eastern Health and St Vincent's Hospital. The catchment areas have expanded with the transition to PHNs, therefore additional hospitals are now participating in HealthPathways. This project has facilitated the development of a suite of palliative care HealthPathways which will be available to GPs on the website in June 2016. The pages will be promoted to GPs in an ongoing manner in order to improve the use of HealthPathways and raise awareness of new content on the website including palliative care pathways. The pathways will undergo regular review of the content by the clinical editors and continue to be promoted and evaluated by the Primary Health Networks who are resourced to continue this work and maintain HealthPathways.

Decision Assist provides regular workshops for GPs, nursing home staff and other health professionals. These workshops provide information on palliative care and advance care planning. The Primary Health Networks also facilitate and promote such workshops providing GPs with ongoing continuing professional development opportunities.

Process changes made within the hospital palliative care units will continue to be implemented in order to improve communication between the hospital and General Practice. This includes the St Vincent's Palliative Care Consultancy e-Form for GPs, improved rates of letter dictation from St Vincent's palliative care outpatients and up-to-date information on referral pathways and specialist contact details provided on the hospital websites. These ongoing initiatives will ensure that improvements made can be sustained beyond the timeframe of the project.

10. Expenditure Report

Budget item	Original forecast amount	Final amount spent	Comment
Total amount (inclusive GST)	\$40,000	\$40,000	All funds were utilised for covering project costs – staffing, implementation, CPD costs etc.

11. Project Manager (Applicant) Signature

I declare that this report is a true and proper representation of the activities undertaken in this project:



A/Prof Brian Le
Director of Palliative Care
The Royal Melbourne Hospital

12. Project Sponsor Signature

I fully endorse this report and its content:
A/Prof Brian Le – Director of Palliative Care, The Royal Melbourne Hospital

13. Participating Hospitals Clinical Leads Signatures

I fully endorse this report and its content:
Dr Jenny Philip – Deputy Director, Palliative Care, St Vincent's Hospital
Dr Cuong Duong - Upper GI Surgeon, Peter MacCallum Cancer Centre

14. Appendices:

- A. GP Survey**
- B. GP Survey Data**
- C. Pre-workshop questionnaire**
- D. Pre-workshop survey reponses**
- E. Post-workshop evaluation form**
- F. Comparison Data – pre and post**
- G. Palliative Care Consultancy e-form**
- H. Project Plan**
- I. Gantt Chart (separate document)**

Appendix A: GP Survey



Brief Questionnaire

GP Integration in Cancer Supportive Care

Most patients want to receive care at home, particularly those with advanced cancer and those receiving end-of-life care. To achieve this, The Royal Melbourne Hospital, St Vincent's Hospital and Peter MacCallum Cancer Centre are collaborating to engage general practitioners to improve care for palliative care patients with advanced cancer.

Please note that the information that you provide in this survey will be non-identified unless you choose to provide your contact details, which implies consent to follow up the survey and invitation to participate in testing any educational resources developed as part of the project. All contact details will be used for project purposes only.

If you would like further information please contact the project managers:

Fiona McCormack - Phone: 8387 2161 Email: fiona.mccormack@mh.org.au

Sita Vij - Phone: 9231 4781 Email: sita.vij@svha.org.au

Please **FAX** this survey back to: **8387 2222**

If you would prefer to complete this survey online, please visit:

www.surveymonkey.com/s/Y6YWTCT

1. Have you cared for a palliative care patient/s with advanced cancer in the last 12 months?

- Yes
- No

2. Did you need to contact someone at the hospital in regard to your patient's care?

- Yes
- No
- Not applicable

3. Who did you contact at the hospital in regard to your patient?

- Treating unit registrar
- Palliative care registrar or consultant
- Treating unit junior doctor
- GP Liaison Unit
- Not applicable
- Other – please specify: _____

4. Do you think that it is your role to care for patients following hospital treatment for advanced cancer?

- Yes
- No - why not? _____

5. Do you feel confident in providing care for palliative care patients?

- Yes
- No - why not? _____

6. What assists you to provide adequate care for patients with advanced cancer?

7. What are the barriers to providing care for patients with advanced cancer?

- Lack of information
- Poor correspondence from the hospital
- Lack of guidelines for palliative care support
- Lack of access to telephone advice from specialist
- Lack of knowledge about local services
- Access to providing home visits
- Other – please specify: _____

8. Do you routinely discuss and / or develop Advance Care Plans / end-of-life plans with your patients?

- Yes
- No

9. What are the barriers to discussing / developing such plans?

- Lack of training
- Lack of appropriate guidelines
- Lack of paperwork to document a plan
- Not a GPs role
- Other – please specify: _____

10. Are you aware of hospital-based palliative care services in your area and how to refer?

- Yes
- No

11. Are you aware of community-based palliative care services and how to refer?

- Yes
- No

12. Are you aware of HealthPathways? <https://melbourne.healthpathways.org.au>

- Yes - please continue to the next question
- No - please skip to question 15

13. Have you used HealthPathways for the assessment and management of your patients?

- Yes
- No

14. Have you used HealthPathways to obtain hospital or community service referral information?

- Yes
- No

15. Do you use any other websites to access information when caring for patients with advanced cancer?

- Yes - which ones? _____
- No

16. Would you be interested in receiving information on common symptom management for palliative care patients with advanced cancer?

- Yes
- No

17. What other resources or information would enable you to provide better care for your palliative care patients?

18. What is your practice postcode? _____

19. Would you like to be involved in any survey follow-up or receive further information about supportive/palliative care including a GP resource pack (developed as part of this project)?

- Yes - please fill in your details below
- No

Name: _____

Address: _____

Email: _____

Phone: _____

Thank you very much for your feedback!

B. GP Survey Data

GP Integration in Cancer Supportive Care Survey Results – August 2015

Purpose

The purpose of the survey was to determine gaps in GP knowledge, system issues and GP needs in providing palliative care for patients with advanced cancer.

Respondents

56 GPs responded to the survey including an online Survey Monkey and hard copy version.

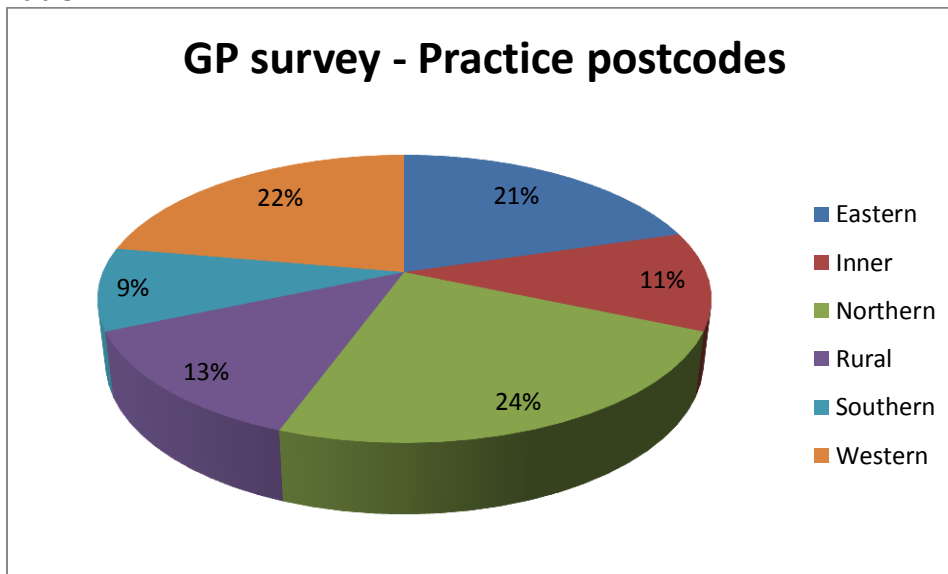
Distribution

The GP survey was distributed widely via Victorian Medicare Locals newsletters, Networking Health Victoria newsletter, through GP events such as the 11 June workshop on Advance Care Planning hosted by Inner East Melbourne Medicare Local, the 25 July Cancer in General Practice workshop facilitated by Peter MacCallum Cancer Centre and Cancer Council Victoria. Surveys were also distributed at a GP professional development session held at St Vincent's Hospital on 23 July and promoted widely via email to local practice managers and engaged GPs.

Demographics of respondents

Practice postcodes were collected as part of the survey.

Table 1



57% of respondents practice in the Northern, Western and Inner Melbourne areas which reflects the catchment areas of Royal Melbourne Hospital and St Vincent's Hospital. All 3 hospitals (Royal Melbourne Hospital, St Vincent's Hospital and Peter MacCallum Cancer Centre) see a large cohort of patients from rural areas - 13% of respondents were from rural areas.

Summary

The majority of respondents had cared for at least one palliative care patient in the past 12 months (almost 82%). Almost half of the respondents who had recent experience of caring for a palliative patient at home needed to contact someone at the hospital regarding the patient's care. The majority of those contacts (62%) were medical registrar level either in palliative care or another treating specialty. The vast majority of respondents felt that it was the role of the GP to provide care for palliative patients.

Almost 70% of respondents felt confident to care for palliative care patients, the remaining 30% of respondents who did not feel confident identified issues such as lack of experience and the complexity of the care required. The most important factors for GPs to provide adequate home care for patients with advanced cancer were identified as community palliative care services and access to hospital support (palliative or other clinical unit). Good communication and access to palliative care management guidelines (including medication management) were also identified by the respondents as quite important in the providing care. Some of the important factors identified as essential to good palliative care at home were also identified as barriers when they were not done well e.g. poor communication (66%) and lack of guidelines (53%).

The majority of respondents (56%) did not routinely discuss end-of-life care or advance care planning with their patients. Respondents identified barriers such as lack of training, lack of available guidelines and lack of time as the major factors preventing these discussions. Respondents were more familiar with the community-based palliative care services (73%) and how to refer than with hospital palliative care teams (65.5%) and referral processes.

HealthPathways is an online tool for GPs that provides evidence-based information on the assessment and management of common medical conditions. It also includes referral information for local hospitals and community services. HealthPathways has been implemented across the Northern and Eastern areas of metropolitan Melbourne in a collaborative arrangement with the North West Melbourne Primary Health Network (PHN), Eastern Melbourne PHN, Royal Melbourne Hospital, Eastern Health and St Vincent's Hospital. Several questions were included in the survey to establish GP knowledge and awareness. 46% of respondents were aware of HealthPathways. Of those, 29% had used it for assessment and/or management of their patients, with 18% having used it to obtain referral information.

37% of respondents used other websites to assist with providing care. 40% of the respondents who used other websites accessed eTG (electronic therapeutic guidelines) and a small number accessed the eviQ (8%) and the Peter MacCallum Cancer Centre website (8%).

The vast majority (94%) of respondents were interested in obtaining more information on common symptom management for patients with advanced cancer and the most popular modes of receiving information included:

Education events	28%
Factsheets/guidelines	20%
Electronic applications/websites	14%
Improved hospital communication	14%
Support services	14%
Improved communication from palliative care service	10%

Recommendations:

The purpose of this project is to improve GP integration in cancer supportive care. This requires a high degree of involvement from all care providers, including care provision in the home. In order for the patient to receive adequate care, minimise disruption, maximise quality of life and prevent unnecessary admissions to hospital, the GP is often at the centre of the care continuum providing care either at home or close by in the general practice.

Activities involved in home care for palliative care patients include patient assessment, medication management and symptom control including pain management. This should also include clarity around the overall plan of care as well as patient and carer goals. Palliative care at home is a team arrangement with the community palliative care service often providing day to day management of and feedback to the GP. The GP, as the medical care provider, relies on accurate and clear communication from both the hospital and community palliative care teams in order to make key decisions about the patient's care. Based on the feedback from the survey, the recommendations to be addressed in the next part of the project include:

Improving communication between healthcare providers (hospital, GP, community palliative care)

- Develop tools that will facilitate better communication and clinical handover e.g. care plan

Improving access to information by developing a resource pack for GPs (including gaps in information as outlined by respondents)

- Develop user-friendly guidelines for GPs to assist with providing palliative and home care for patients with advanced cancer
- Utilise HealthPathways as tool for guideline development

Facilitating GP education in identified gap areas to improve knowledge and skills

- Develop educational series/short course for GPs in collaboration with the PHN

Summary of Responses

Question 1

Have you cared for a palliative care patient/s with advanced cancer in the last 12 months?		
Answer Options	Response Percent	Response Count
Yes	81.8%	45
No	18.2%	10
answered question		55
skipped question		1

Question 2

Did you need to contact someone at the hospital in regard to your patient's care?		
Answer Options	Response Percent	Response Count
Yes	47.3%	26
No	32.7%	18
Not applicable	20.0%	11
answered question		55
skipped question		1

Question 3

Who did you contact at the hospital in regard to your patient?		
Answer Options	Response Percent	Response Count
Treating unit registrar	32.0%	16
Palliative care registrar or consultant	30.0%	15
Treating unit junior doctor	4.0%	2
GP Liaison Unit	4.0%	2
Not applicable	42.0%	21
Other (please specify)	14.0%	7
answered question		50
skipped question		6

Other:

Palliative care nurses, community palliative care services, physicians/specialists

Question 4

Do you think that it is your role to care for patients following hospital treatment for advanced cancer?		
Answer Options	Response Percent	Response Count
Yes	94.5%	52
No	5.5%	3
If no, why not?		6
answered question		55
skipped question		1

If no, why not?

- “Partially, with the team”
- “Yes and no - with my current patient who is having palliative care nurses visits at home most days since she was discharged from hospital, there was no communication from the hospital or palliative care to me regarding the expectation that I would be the one who wrote up her medication charts and did her scripts. I work part-time and my colleagues aren't always able to do this work when I'm not there. I actually don't think it's always appropriate for the GPs to manage the at-home care of patients who are dying, as we don't have the knowledge re drugs, or the time (most GPs are not working Mon-Fri) or the skills to manage this, and our patients can be left waiting for the medications that they need”
- “I don't have the expertise”

Question 5

Do you feel confident in providing care for palliative care patients?		
Answer Options	Response Percent	Response Count
Yes	69.1%	38
No	30.9%	17
If no, why not?		20
answered question		55
skipped question		1

Why not - summary of responses:

Lack of experience	47%
Complexity of care	33%
Lack of support & poor communication	20%

Question 6

What assists you to provide adequate care for patients with advanced cancer?

53 responses, 3 skipped question

Summary of comments:

- Local palliative care teams and services
- Developing relationships with service providers and palliative care specialists
- Understanding how to navigate the system
- Access to advice/ability to contact a specialist if needed
- Guidance from palliative care team
- Easy access to information
- Ability to get the patient seen (request a consultation without barriers)
- Good communication with patient or their carer and family/social supports
- Clear/timely communication from the hospital re: diagnosis, treatment, prognosis, follow-up, medications, symptom management, discharge summary, who to contact if issues arise, expectations of GP
- List of specific treatments, medications, expected side effects and how to manage these
- Awareness of support systems - from family/friends to specialised palliative services especially someone to talk to over the phone
- Adequate knowledge/experience/education/training

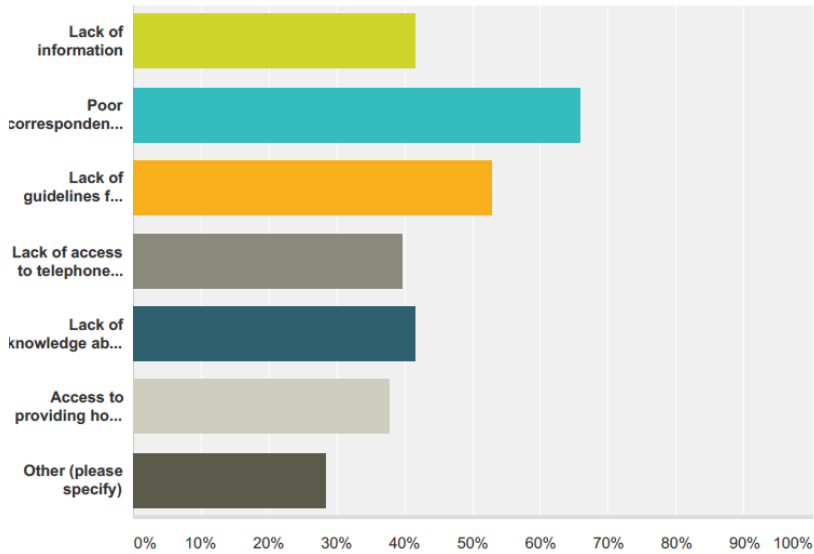
Themes:

Community palliative care services	33%
Hospital support/access to advice	24%
Good communication	16%
Guidelines for palliative care management (inc. meds)	11%
Support services	8.5%
Adequate knowledge/experience in palliative care	5%
Good care plan	1.25%
Remuneration	1.25%

Question 7

What are the barriers to providing care for patients with advanced cancer?

Answer Options	Response Percent	Response Count
Lack of information	41.5%	22
Poor correspondence from the hospital	66.0%	35
Lack of guidelines for palliative care support	52.8%	28
Lack of access to telephone advice from specialist	39.6%	21
Lack of knowledge about local services	41.5%	22
Access to providing home visits	37.7%	20
Other (please specify)	28.3%	15
answered question		53
skipped question		3



Other – summary of comments:

- Ability to get patient seen (e.g. specialist home visit)
- Access to providing home visits
- Patient and family should be able to contact their doctor 24/7
- Lack of information from treating hospital and palliative care/delay in receiving correspondence
- Lack of time
- Lack of training/experience
- Poor financial reimbursement
- Lack of support from allied health
- Lack of patient desire

Additional information:

Lack of time and remuneration as well as lack of experience were the other main issues identified as barriers in providing care for patients with advanced cancer

Question 8

Do you routinely discuss and / or develop Advance Care Plans / end-of-life plans with your patients?		
Answer Options	Response Percent	Response Count
Yes	43.6%	24
No	56.4%	31
answered question		55
skipped question		1

Question 9

What are the barriers to discussing / developing such plans?		
Answer Options	Response Percent	Response Count
Lack of training	49.0%	24
Lack of appropriate guidelines	42.9%	21
Lack of paperwork to document plan	40.8%	20
Not a GPs role	4.1%	2
Other (please specify)	46.9%	23
answered question		49
skipped question		7

Other – summary of comments:

- Time constraints
- May not be appropriate to broach subject with patient and family
- Only done if requested by patient
- Patient's unwillingness to accept diagnosis
- Cultural sensitivity around these issues is important
- Lack of coordination about where a completed advance care plan is recorded and who has access
- Unsure about formal documentation of a plan

Themes:

Lack of time	45%
Family/Patient/Cultural issues	27%
Inappropriate (demographic)	14%
Uncertain of process	9%
Already done	5%

Question 10

Are you aware of hospital-based palliative care services in your area and how to refer?		
Answer Options	Response Percent	Response Count
Yes	65.5%	36
No	34.5%	19
answered question		55
skipped question		1

Question 11

Are you aware of community-based palliative care services and how to refer?		
Answer Options	Response Percent	Response Count
Yes	72.7%	40
No	27.3%	15
<i>answered question</i>		55
<i>skipped question</i>		1

Question 12

Are you aware of HealthPathways? (https://melbourne.healthpathways.org.au)		
Answer Options	Response Percent	Response Count
Yes - please continue to the next question	46.3%	25
No - please skip to question 15	53.7%	29
<i>answered question</i>		54
<i>skipped question</i>		2

Question 13

Have you used HealthPathways for the assessment and management of your patients?		
Answer Options	Response Percent	Response Count
Yes	28.6%	8
No	71.4%	20
<i>answered question</i>		28
<i>skipped question</i>		28

Question 14

Have you used HealthPathways to obtain hospital or community service referral information?		
Answer Options	Response Percent	Response Count
Yes	17.9%	5
No	82.1%	23
<i>answered question</i>		28
<i>skipped question</i>		28

Question 15

Do you use any other websites to access information when caring for patients with advanced cancer?		
Answer Options	Response Percent	Response Count
Yes	37.3%	19
No	62.7%	32
If yes, which ones?		22
answered question		51
skipped question		5

Summary of comments:

- eTG/Therapeutic guidelines 40%
- eviQ 8%
- Cancer council 8%
- Peter Mac 4%
- Clinical guidelines 4%
- Google 4%
- Decision Assist 4%
- Government DHS website 4%
- Australian Doctor, AFP 4%
- PubMed 4%
- Medscape, UpToDate 4%
- Caresearch 4%
- Advancecareplanning.org.au 4%
- MIMS 4%

Question 16

Would you be interested in receiving information on common symptom management for palliative care patients with advanced cancer?		
Answer Options	Response Percent	Response Count
Yes	94.3%	50
No	5.7%	3
answered question		53
skipped question		3

Question 17

What other resources or information would enable you to provide better care for your palliative care patients?	
Answer Options	Response Count
	27
answered question	27
skipped question	29

Summary of comments:

- Education, workshops, webinars, clinical placements
- iPhone/smartphone app, PalliAged app, palliative care websites
- Contact lists (email, phone) for specialists, allied health
- Good GP communication/feedback from hospital and guidelines/fact sheets
- Referral protocols
- Prescribing advice
- Timely discharge summaries and phone call

Themes:

Education events	28%
Factsheets/guidelines	20%
Electronic applications/websites	14%
Improved hospital communication	14%
Support services	14%
Improved communication from palliative care service	10%

Question 18

What is your practice postcode?	
Answer Options	Response Count
	54
<i>answered question</i>	54
<i>skipped question</i>	2

Question 19

Would you like to be involved in any survey follow-up or receive further information about supportive/palliative care including a GP resource pack (developed as part of this project)?		
Answer Options	Response Percent	Response Count
Yes - please fill in your details below	69.2%	36
No	30.8%	16
<i>answered question</i>		52
<i>skipped question</i>		4

C. Pre-workshop questionnaire

Pre-Workshop Survey

Living Longer, Dying Better: A Framework of Palliative Care for Older Australians living in the Community

HealthPathways Palliative Care GP Resource Pack

Before attending the Palliative Care in General Practice Workshop on 23 February, please complete this survey to enable us to ensure that the content meets educational needs.

In trying to improve resources for GPs caring for palliative care patients in the community, we have developed a Palliative Care GP Resource Pack in collaboration with HealthPathways Melbourne. We would appreciate your review of the resource pack and completion of some questions relating to the resource pack.

Please visit the Health Pathways Melbourne draft site:
<http://melbournedraft.healthpathways.org.au/234284.htm> and enter login details
(username: melbourne Password: cup)

If you would like further information please contact the project managers:
Fiona McCormack - phone: 8387 2161 or email: fiona.mccormack@mh.org.au
Sita Vij - phone: 9231 4781 or email: sita.vij@svha.org.au

1. Please rate your understanding of palliative care:

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly Disagree
a) I feel confident to provide palliative care to older persons					
b) I am aware of the principles of a palliative care approach apply to the clinical management of frail older persons and those with advanced chronic disease					
c) I am aware of the benefits of using a framework of care based on prognostic trajectories to identify the palliative care needs of older persons					
d) I feel confident that advance care planning discussions and documentation can inform timely and appropriate clinical care to older persons					
e) I feel confident that participating in at least one palliative care case conference in the patient's last few months of life can support timely and appropriate end of life care					
f) I am confident that end of life management plans can be used to support a patient to die at home if that is their stated wish					

2. Have you visited the HealthPathways website before?

<https://melbourne.healthpathways.org.au>

- Yes
 No

3. Are you aware that HealthPathways provides assessment, management and referral information?

- Yes
 No

4. Do you think you will use HealthPathways in future?

- Yes
 No – why not: _____

5. How useful is the information provided in the GP Palliative Care Resource Pack? <http://melbournedraft.healthpathways.org.au/234284.htm>

- Very useful
 Somewhat useful
 Not useful at all – why not: _____

6. Please rate the information provided in the GP Palliative Care Resource Pack:

	Extremely useful/relevant	Fairly useful/relevant	Not very useful/relevant	Very unhelpful/ of no relevance
Advance Care Planning				
Aged Care				
Bereavement, Grief and Loss				
Clinical management				
Education and online learning modules				
Medication				
Paediatric palliative care				
Special groups				
Support services				

7. Are there any topics missing from the resource pack that would be useful?

8. Would you be interested in accessing further information on the management of palliative care patients?

- Yes – please check back with HealthPathways as the palliative care pathways continue to be developed: <https://melbourne.healthpathways.org.au> (Username: connected Password: healthcare)
 No

9. What is your practice postcode? _____

We look forward to seeing you at the Palliative Care in General Practice workshop:
 Tuesday 23 February 2016
 7:00pm-9:00pm (registrations from 6:30pm)
 St Vincent's Hospital Healy Wing
 41 Victoria Parade, Fitzroy - Education Centre, Level 3

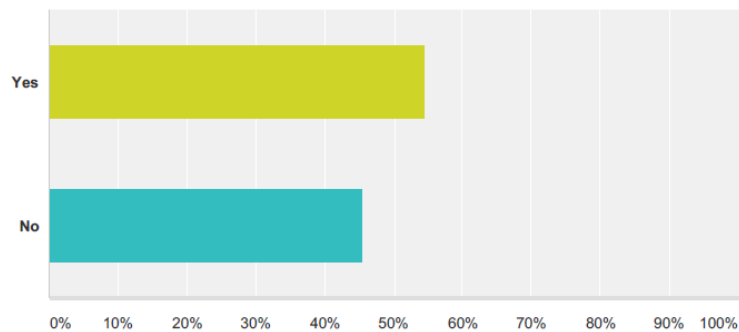
D. Pre-Workshop Survey Responses

Pre-Workshop Survey: Palliative Care in General Practice

Q1 Please respond to the questions below regarding the management of palliative care patients

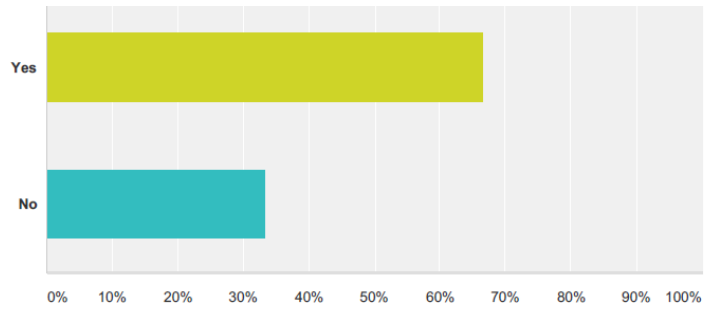
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total
I feel confident to provide palliative care to older persons	6.25% 2	59.38% 19	21.88% 7	12.50% 4	0.00% 0	32
I am aware of the principles of a palliative care approach to the clinical management of frail older persons and those with advanced chronic disease	9.68% 3	61.29% 19	22.58% 7	6.45% 2	0.00% 0	31
I am aware of the benefits of using a framework of care, based on prognostic trajectories, to identify the palliative care needs of older persons	3.13% 1	65.63% 21	25.00% 8	6.25% 2	0.00% 0	32
I feel confident that advance care planning discussions and documentation can inform timely and appropriate clinical care to older persons	18.75% 6	56.25% 18	18.75% 6	6.25% 2	0.00% 0	32
I feel confident that participating in at least one palliative care case conference in the patient's last few months of life can support timely and appropriate end of life care	6.25% 2	68.75% 22	25.00% 8	0.00% 0	0.00% 0	32
I am confident that end of life management plans can be used to support a patient to die at home if that is their stated wish	9.38% 3	81.25% 26	9.38% 3	0.00% 0	0.00% 0	32

Q2 Have you visited the HealthPathways website before?
<https://melbourne.healthpathways.org.au>



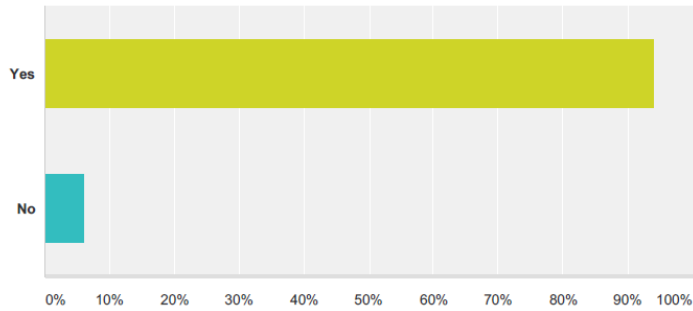
Answer Choices	Responses	Total
Yes	54.55%	18
No	45.45%	15
Total		33

Q3 Are you aware that HealthPathways provides assessment, management and referral information?



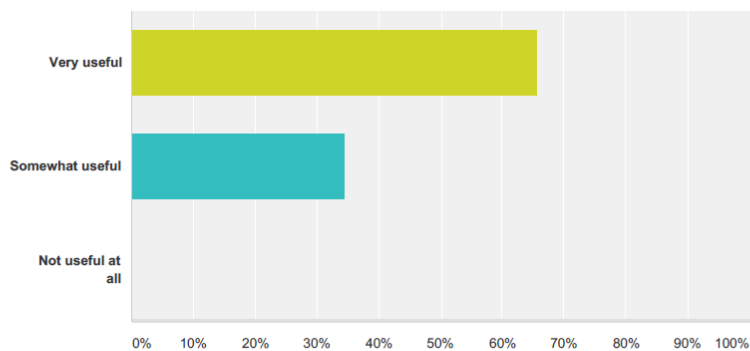
Answer Choices	Responses	Count
Yes	66.67%	22
No	33.33%	11
Total		33

Q4 Do you think you will use HealthPathways in future?



Answer Choices	Responses	Count
Yes	93.94%	31
No	6.06%	2
Total		33

Q5 How useful is the information provided in the GP Palliative Care Resource page on HealthPathways?



Answer Choices	Responses	Count
Very useful	65.63%	21
Somewhat useful	34.38%	11
Not useful at all	0.00%	0
Total		32

Q6 Please rate the information provided in the GP Resource page on HealthPathways

	Very useful	Useful	Somewhat useful	Not useful at all	Total
Advance care planning	21.43% 6	71.43% 20	3.57% 1	3.57% 1	28
Aged care	17.24% 5	68.97% 20	13.79% 4	0.00% 0	29
Bereavement, grief and loss	25.00% 7	57.14% 16	17.86% 5	0.00% 0	28
Clinical management	35.71% 10	50.00% 14	14.29% 4	0.00% 0	28
Education and online learning modules	18.52% 5	66.67% 18	14.81% 4	0.00% 0	27
Medication	39.29% 11	53.57% 15	7.14% 2	0.00% 0	28
Paediatric palliative care	14.29% 4	60.71% 17	21.43% 6	3.57% 1	28
Special groups	10.71% 3	57.14% 16	32.14% 9	0.00% 0	28
Support services	25.93% 7	51.85% 14	22.22% 6	0.00% 0	27

Q7 Are there any topics missing from the resource page that would be useful to manage palliative care patients?

Responses
n/a
Development of a universal suitable medication chart by/with Palliative Care Services to be used at patients' homes, which is computer based and compatible with common GP medical record software. Handwriting orders for home medications when the GP practice is computerised is inefficient and prone to errors. Also it is yet another handwritten document, when records are computerised
it looks very comprehensive, links to religious organisations perhaps
Not that I can think of
not sure
none
Seems all are covered
I can't think of any.
nil
how to deal with the cultural differences of patients/ families in discussion of ACP and PALL CARE in aged care and GP / community .

Q8 Would you be interested in accessing further information on the management of palliative care patients?

Answer Choices	Responses	
Yes - please check HealthPathways for further developments: https://melbourne.healthpathways.org.au	93.10%	27
No	6.90%	2
Total		29

Q9 What is your practice postcode?

Postcode	N
3000	1
3023	2
3032	1
3043	1
3046	1
3052	1
3054	1
3055	2
3056	3
3076	1
3085	1
3102	1
3109	1
3121	5
3138	1
3150	1
3162	1
3171	1
3222	1
3442	1
3443	1
3444	1

E. Post-workshop evaluation form



Living Longer, Dying Better: A Framework of Palliative Care for Older Australians Living in the Community

Post-workshop evaluation form

1. What is the postcode of your (primary) work location? _____

2. Please rate to what degree the learning objectives of the workshop were met. **Please v**

Learning objective	Rating		
	Not met	Partially met	Entirely met
Explain the contemporary scope of palliative care and its importance in supporting the clinical management of older Australians			
Implement a framework of care, based on prognostic trajectories, to proactively determine the palliative care needs of older Australians to ensure safe and effective practice			
Access new resources and advisory services provided by Decision Assist			

3. Please rate to what degree your learning needs were met.

Not met	Partially met	Entirely met

4. Please rate to what degree this activity is relevant to your practice.

Not relevant	Partially relevant	Entirely relevant

Qs 5 – 15: Please tick (✓) to indicate your extent of agreement with **each** of the following statements:

	Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
5. I understand how to provide palliative care to older Australians.					
6. I understand how the principles of a palliative care approach apply to the clinical management of frail older individuals and those with advanced chronic disease.					
7. I understand the benefits of using a framework of care, based on prognostic trajectories, to identify the palliative care needs of older Australians.					

	Agree strongly	Agree	Neither agree nor disagree	Disagree	Disagree strongly
8. I understand how advance care planning discussions and documentation can inform timely and appropriate clinical care to older Australians.					
9. I understand how participating in at least one palliative care case conference in the patient's last few months of life can support timely and appropriate end of life care.					
10. I understand how end of life management plans can be used to support a patient to die at home if that is their stated wish.					
11. I am confident in my practice of palliative care for older Australians.					
12. I am confident to use a framework of care, based on prognostic trajectories, to identify the palliative care needs of older Australians.					
13. I am aware of new resources and advisory services available to GPs in the areas of advance care planning and palliative care through Decision Assist.					
14. A palliative care approach is standard practice for frail older patients and those with advanced chronic disease.					
15. A framework of care, based on prognostic trajectories, is a useful tool to help identify the palliative care needs of frail older patients and those with advanced chronic disease.					

16. Would you be likely to use new resources and advisory services available to GPs in the areas of advance care planning and palliative care through Decision Assist?	Yes	No	Unsure

17. What is one new idea you will consider implementing in your practice as a result of attending the workshop?

18. If you would like to add any comments please do so below:

Thank you for taking the time to complete this form.
We appreciate your feedback.

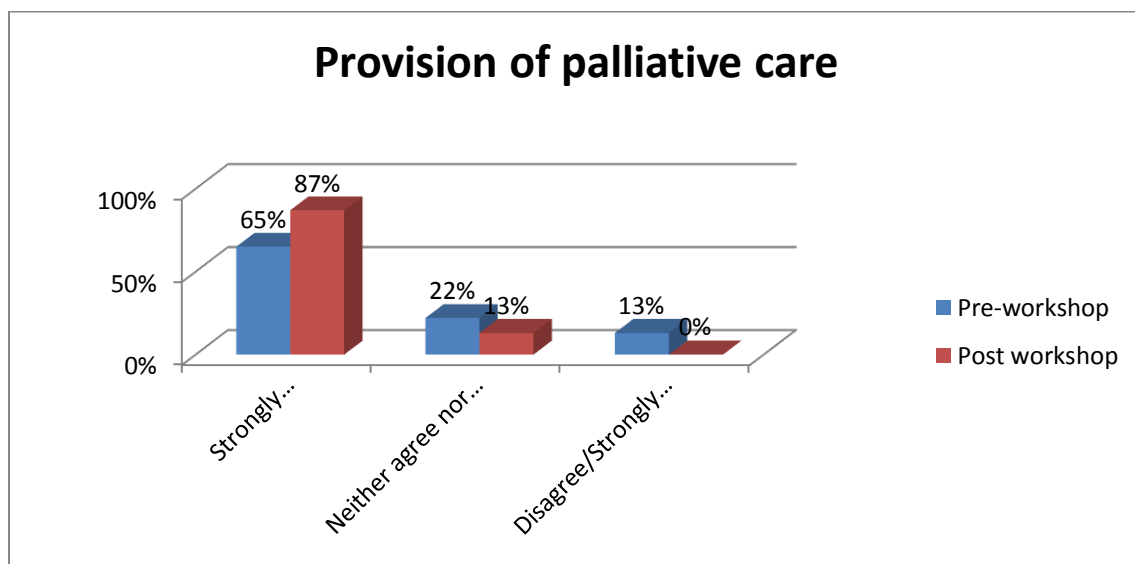
F. Comparison Data – pre and post

GP Integration in Cancer Supportive Care Pre and post CPD workshop evaluation February 2016

As part of the project interventions, a Decision Assist palliative care GP workshop was run at St Vincent's Hospital on February 23rd 2016 with 44 GPs registered to attend and 31 participants on the night (18 GPs). In order to determine a baseline knowledge level for workshop participants, a pre-workshop survey was developed which contained 6 questions from the Decision Assist post-workshop evaluation. The survey also requested that participants provide feedback on the draft HealthPathways palliative care GP resource page. 32 registered workshop participants completed the pre-workshop survey and 24 completed the post-workshop survey. This report outlines the results of the pre and post-workshop evaluation.

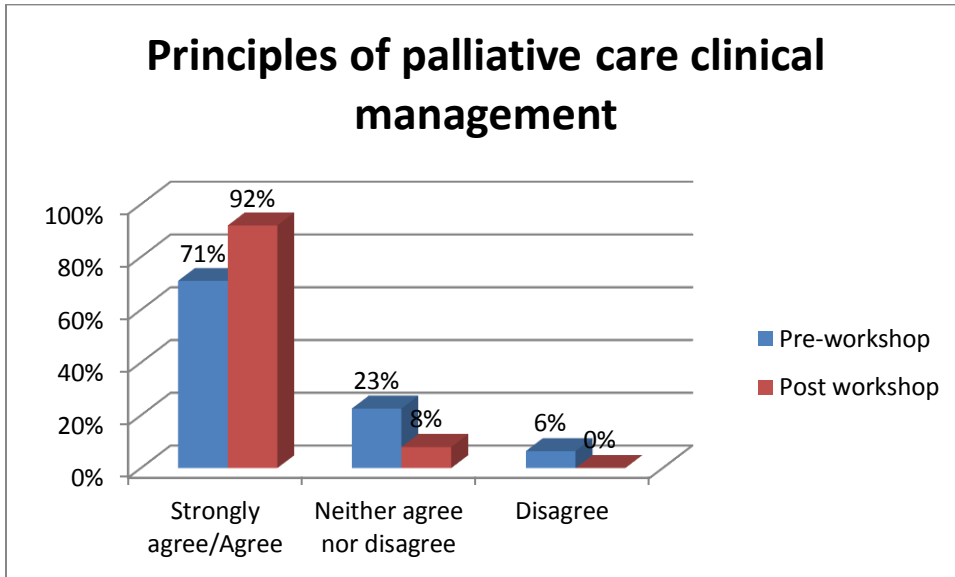
1. PRE AND POST EVALUATION QUESTIONS DECISION ASSIST WORKSHOP

Question 1 – I feel confident/understand how to provide palliative care to older people



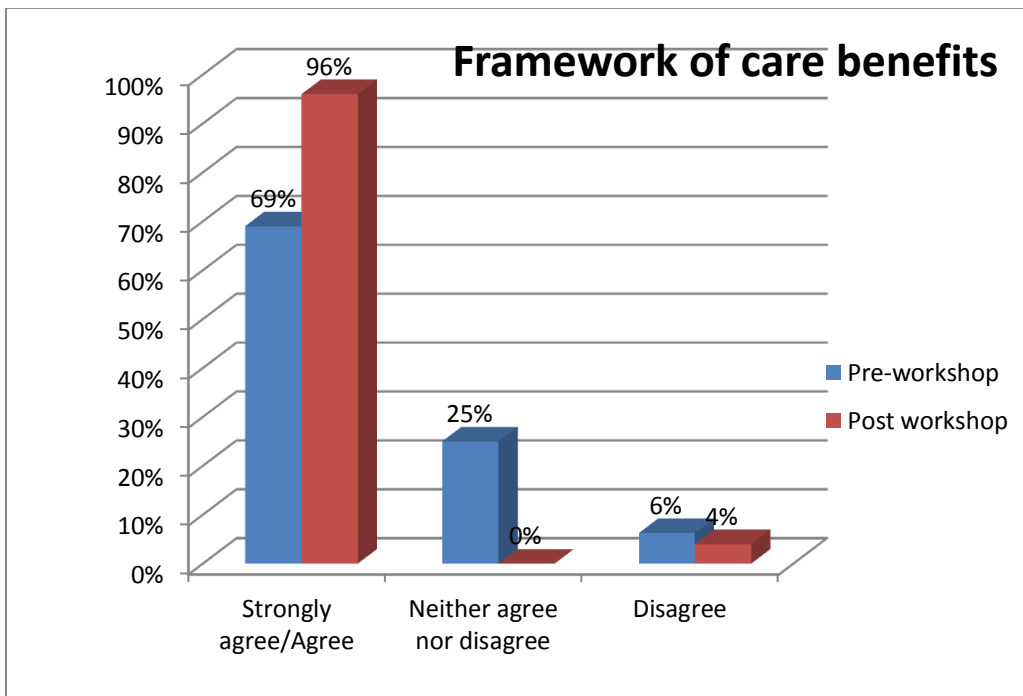
This result indicates that participants felt significantly more confident/had a better understanding of how to provide palliative care after the workshop demonstrated by a 22% increase in the positive response ratings for this question.

Question 2 – I am aware/understand how the principles of a palliative care approach apply to the clinical management of frail older persons and those with advanced chronic disease



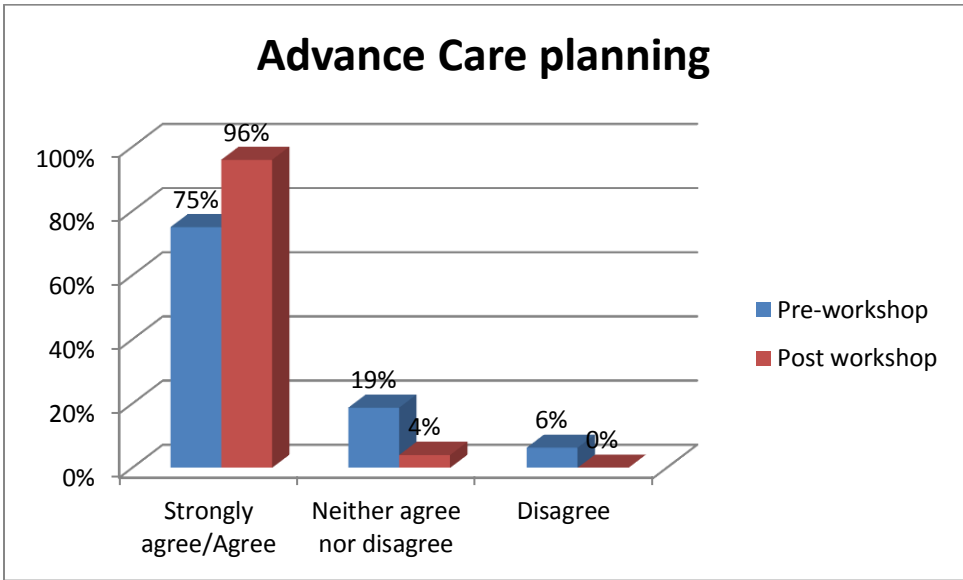
This result indicates a significant increase in participant’s knowledge and understanding of how to apply the palliative care clinical management framework post-workshop with a 22% increase in positive responses.

Question 3 - I understand/am aware of the benefits of using a framework of care, based on prognostic trajectories, to identify the palliative care needs of older people



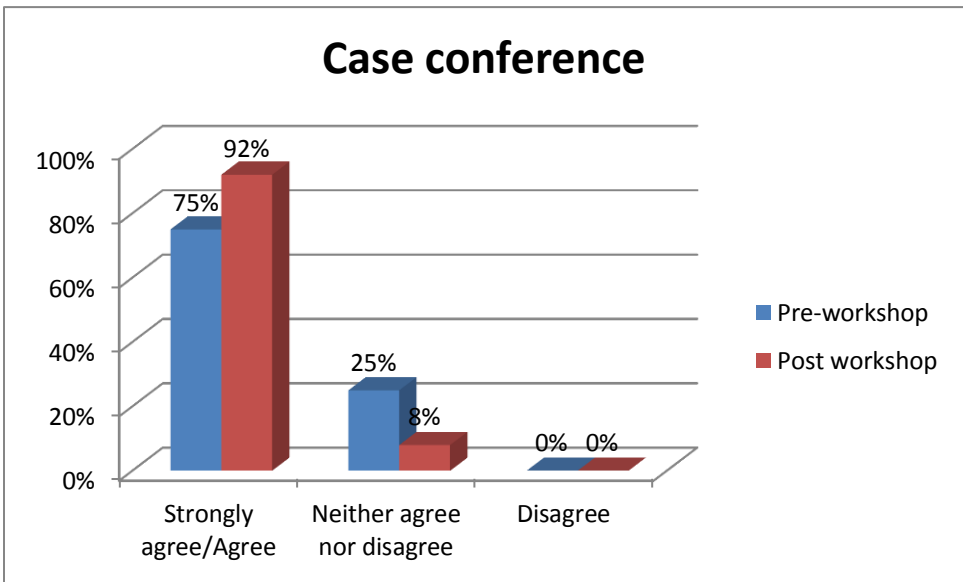
This result indicates a strong increase in participant’s knowledge and understanding of the benefits of using the framework of care with an increase of 27% in positive responses to this question post-workshop.

Question 4 – I understand/feel confident that Advance Care Planning discussions and documentation can inform timely and appropriate clinical care to older persons



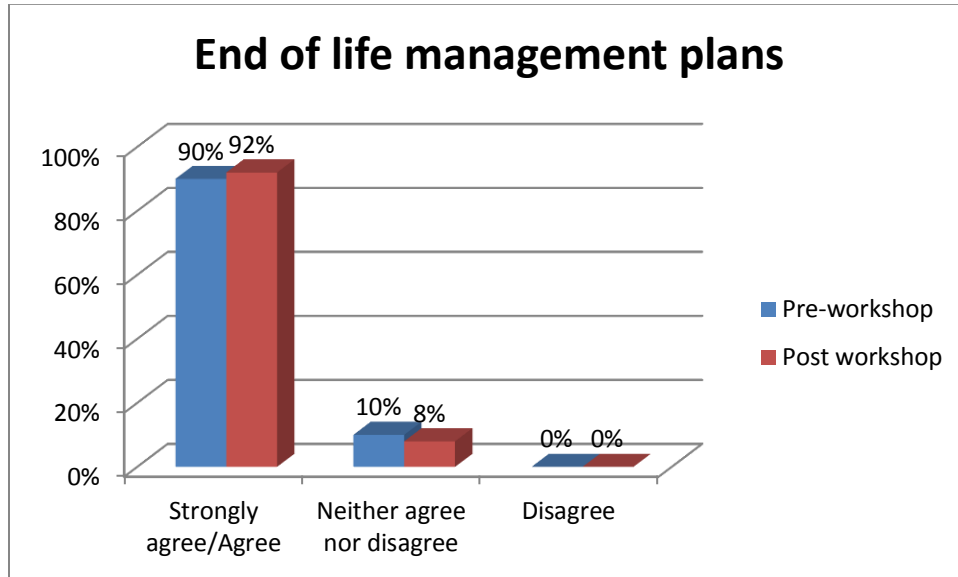
This result indicates another strong increase in knowledge about the benefits of Advance Care Planning post-workshop with an increase in positive responses of 21%.

Question 5 – I understand/feel confident that participating in at least one palliative care case conference in the patient’s last few months of life can support timely and appropriate end of life care



This result indicates a significant increase in participant’s level of understanding of the benefits of case conferencing with an increase of 17% in positive responses post-workshop.

Question 6 – I understand/am confident in how end of life management plans can be used to support a patient to die at home if that is their stated wish



This result indicates that there was a high level of knowledge around end of life management plans amongst participants and their usefulness prior to the workshop with only a small increase of 2% post-workshop. 90-92% of participants provided positive responses to this question both pre and post-workshop.

2. HEALTHPATHWAYS PALLIATIVE CARE RESOURCE PAGE EVALUATION

As part of the pre-workshop survey, registered participants were asked a number of questions via an online survey about HealthPathways in general and requested to rate some of the information on the draft palliative care GP resource page. These results will be provided to the HealthPathways team working on the palliative care pathways. Number of responses: 56

Have you visited the HealthPathways website before?

55% of respondents had visited the site previously and 45% had not.

Are you aware that HealthPathways provides assessment, management and referral information?

67% of respondents were aware and 33% were not.

Do you think you will use HealthPathways in the future?

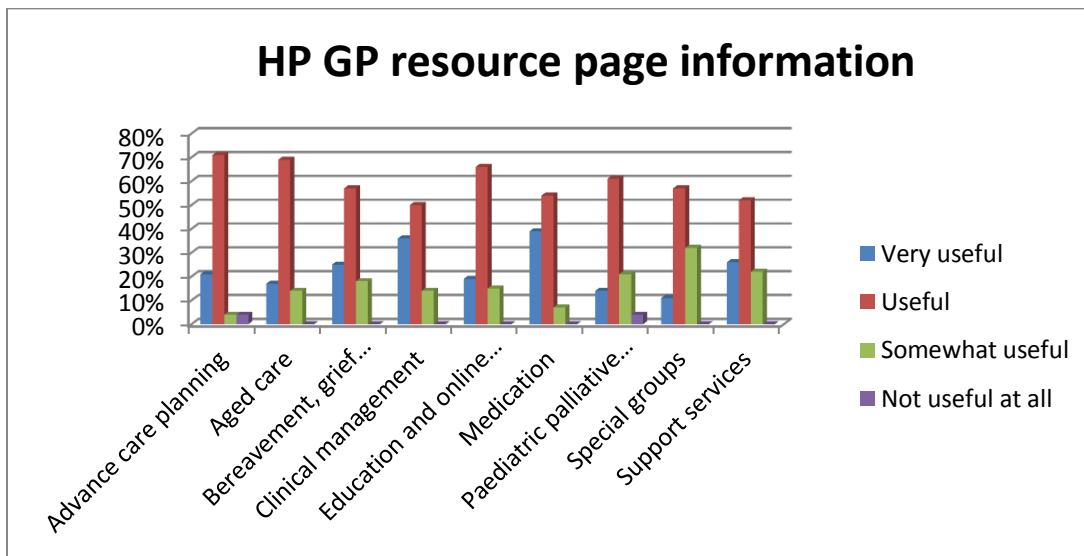
94% of respondents would and 6% would not.

Question – How useful is the information provided in the GP palliative care resource page on Health Pathways?

Answer Options	Response Percent
Very useful	66%
Somewhat useful	34%
Not useful at all	0%

Question - Please rate the information provided in the GP Resource page on HealthPathways:

Answer Options	Very useful	Useful	Somewhat useful	Not useful at all
Advance care planning	21%	71%	4%	4%
Aged care	17%	69%	14%	0%
Bereavement, grief and loss	25%	57%	18%	0%
Clinical management	36%	50%	14%	0%
Education and online learning modules	19%	66%	15%	0%
Medication	39%	54%	7%	0%
Paediatric palliative care	14%	61%	21%	4%
Special groups	11%	57%	32%	0%
Support services	26%	52%	22%	0%



Question - Are there any topics missing from the resource page that would be useful to manage palliative care patients?

Comments:

- Development of a universal suitable medication chart by/with Palliative Care Services to be used at patients' homes, which is computer based and compatible with common GP medical record software. Handwriting orders for home medications when the GP practice is computerised is inefficient and prone to errors. Also it is yet another handwritten document, when records are computerised
- How to deal with the cultural differences of patients/ families in discussion of ACP and PALL CARE in aged care and GP / community

G. Palliative Care Consultancy e-form

NewForm_STVE00276_25065 - Microsoft Internet Explorer provided by St Vincent's Health

TEST, PATIENT MALE
URNO: 775049 (SVH), Sex: M, DOB: 01-Jan-1980

Palliative Care Consultancy Letter

St. Vincent's Palliative Care Consultancy Service

Date

This patient was seen by the Palliative Care Consultancy for:
[Select...]

Admission date **Discharge date**

Diagnosis:

Font Style: **B** *I* U A_x A^x Undo/Redo: Alignment: Paragraph Style: Normal Indenting and Lists:

Main issues addressed:

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Management:

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Referrals made:

Community Palliative Care Referrals:

[Select...]

Discharge medications

MEDICATION	DOSAGE	FREQUENCY	INDICATION	NOTES	REVIEW DATE AND RESPONSIBILITY
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Add

Contact details:

For queries and advice, please contact:

Palliative Care Clinical Nurse Consultant
Phone: (03) 9231 2827 (or via switchboard 9231 2211 and page 1335)
Email: pallcareconsult@svha.org.au

Reviewed by:

H. Project Plan



- *WCMICS Project Plan* -

PROJECT DETAILS

1. Project Title (as per project application)

Improving General Practitioner Integration in Cancer Supportive Care in Advanced Disease

2. WCMICS Hospital/Health Service (Project Site)

The Royal Melbourne Hospital, Peter MacCallum Cancer Centre, St Vincent's Hospital

3. Project Objective & Expected Outcomes (clearly describe the objective of the project and any expected outcomes – less than 300 words)

Project Objectives:

Identify General Practitioner perceptions of and barriers to the provision of care to patients with advanced cancer receiving supportive and palliative care.

Develop an education and resource package to address barriers in provision of high-quality supportive care to those with advanced cancer in the community, and GP evaluation of the impacts of this education and resources.

Outcomes:

A clear understanding of the perceptions of GPs in the provision of care to patients with advanced cancer – encompassing a vision of their role, barriers and facilitators to care and an exploration of their knowledge and integration with existing oncology and palliative care services. An education/resource package – which may include details of hospital and community based supportive and palliative care providers (including how and when to refer), quick reference guides on common symptom management approaches, and a communication guide to assist in introduction of discussion points around advanced care planning, introducing palliative care and end-of-life care discussions.

Analysis and evaluation of GP abilities and knowledge following implementation of the education and resource package.

4. Priority Areas Addressed by Project

<input type="checkbox"/>	Breast	<input type="checkbox"/>	Central Nervous Systems
<input type="checkbox"/>	Colorectal	<input type="checkbox"/>	Genito-urinary
<input type="checkbox"/>	Gynaecology	<input type="checkbox"/>	Haematology
<input type="checkbox"/>	Head & Neck	<input type="checkbox"/>	Lung
<input type="checkbox"/>	Skin/Melanoma	<input type="checkbox"/>	Upper GI
<input checked="" type="checkbox"/>	All		

PROJECT METHODOLOGY

5. Project Overview (per project application with additional comments/ amendments as required – less than 700 words)

Most patients want to receive care at home, particularly those with advanced cancer and those receiving end-of-life care. To achieve this often requires re-engagement with general practitioners (GPs) who may have had little involvement during cancer treatment (e.g. surgery and chemotherapy). Furthermore GPs may have had little experience in cancer supportive and palliative care, and have had little interaction with palliative care services. Another challenge is that patients frequently move between hospital and home, and across regions where they are cared for by different hospital and community-based palliative care providers. This leads to fragmented, often poorly coordinated care, which could be greatly improved by an engaged, skilled GP.

Preliminary findings from the WCMICS GP Communication Project (August 2014) highlighted the often unrecognised important role that GPs have in cancer care. This project focused on communication regarding chemotherapy treatments, and found that all surveyed patients had a routine GP, and that more than 50% of patients consulted their GP many times or routinely during cancer treatment, often times seeking consultation with their GP for chemotherapy related matters.

In what remains the largest and most cited study of factors of importance to patients and families at end-of-life, Steinhauser (JAMA Nov 2000) identified key tasks where GPs implicitly can and should lead care, including pain and symptom management in the community setting, decisions about treatment preferences (and advanced care planning), being treated as a “whole person”, and preparation for death. GPs are well placed to facilitate the achievement of these factors since they often have the most longstanding relationships with patients and their families of all health care providers. It remains unclear however to what extent GPs are trained and capable of managing these sorts of issues for this group of patients.

This project seeks to explore GPs’ perceptions of their role and highlight barriers in delivering supportive and palliative care in the community. These findings will be used to develop an education/resource package. The overarching aim of this project is to empower GPs to remain actively involved and confident to provide high-quality care, in conjunction with oncology and palliative care specialist services.

6. Methodology

Describe the project's methodology including details of how the project will be implemented. Please complete and attach a detailed Gantt Chart which includes the project stages and timelines. Provide a summary in the table below.

The project will be conducted in two phases:

Phase I: Survey of GPs within the current Inner North West Melbourne Medicare Local and Inner East Melbourne Medicare Local (both share catchment with the participating sites). Response rates will be maximized using successful methodology developed for another WCMICS project (led by Mr Cuong Duong – 64% overall response rate), using directed surveys and reminders from hospital GP liaison officers and Medicare Local / Primary Health Network (including clinical council) contacts.

Phase II: Development and implementation of an education/resource package, and GP evaluation of the education program and resources

Stage	Description	Timeline	Outputs	Measures
Recruitment	Recruitment of Project Manager	March - April 2015	Project manager appointed	Successful Appointment
Commencement	Initial meeting with sites and project protocol completion Engagement with Inner North West Melbourne Medicare Local and Inner east Melbourne Medicare Local	April - May 2015	Initiation Meeting Protocol completion	Final protocol GP engagement
Development of Survey	Development of Survey and further GP engagement	May - June 2015	Survey complete	Final Survey
Ethics Application	Submission of survey to Ethics (Low-Risk Ethics Application)	May 2015	Ethics Approval obtained	Ethics Approval obtained
Distribution of Survey	Survey Distribution Response enhancement process – reminders/incentives drive	May – July 2015	Surveys distributed	Satisfactory response rate
Survey analysis	Survey Analysis	July – August 2015	Surveys analysed	Compilation of findings
Development of Education / Resources for GPs	During and following analysis of survey – development of education package and resources	July – September 2015	Education / Resource package developed	Successful education package developed
Delivery of Education / Resources	Delivery of education package to GPs Refinement of education package (pending initial evaluation results)	September – December 2015	Education / Resource package delivered to GPs in region	Education delivered
GP Evaluation of Education and Resources	Evaluation of Education Program and Resources	January - February 2016	Evaluation	Utility of program analysed
Final Evaluation	Final collation of data and preparation of Project Report	March – April 2016	Final Report	

7. Project Scope (define the extent and limits of the project)

Inclusions *(Clearly detail what is included as part of the project, including any anticipated improvements/changes in practice arising from the project):*

Survey of GPs, Survey Findings, Education Package (education sessions and resources), evaluation of education/resources from GPs, project report

Exclusions *(Clearly detail what will not be included as part of the project):*

Ongoing delivery of education sessions after conclusion of project

8. Changes to Project

Detail any changes in methodology or expected outcomes from the Project Application, specifying the reason for the change.

Delivery of Education / Resources has been brought forward in the project timeline – as suggested by the review panel – to enable evaluation and amendments as necessary, and also to bring education program away from end-of-year time-period.

Following development of the education / resources, we will explore linkages with the existing HealthPathways Program, to continue dissemination after the conclusion of this project.

Project team also now includes each hospital's GP liaison officers, and further GPs anticipated to be recruited once project protocol further developed and GPs further engaged.

9. Communication Strategy/Project Stakeholders

Detail how the project progress and outcomes will be communicated to relevant stakeholders and list all relevant project stakeholders. Please also detail any collaboration between WCMICS hospitals/health services.

Key stakeholders include GPs, WCMICS and affiliated hospitals including The Royal Melbourne Hospital, St Vincent's Hospital and Peter MacCallum Cancer Centre. Each site will have an allocated lead Clinician and GP Liaison officers will be engaged. The project will be coordinated and led by the project team and project manager. All sites will be involved in a project start up meeting and regular meetings after each stage of the project. The results will be published in a peer reviewed journal that is accessible to all project stakeholders including GPs. If possible, the project team will explore linkages of the developed resources and education with the HealthPathways Program to ensure continued dissemination after the project conclusion.

10. Evaluation

Detail how the outcomes of the project will be measured (i.e. outputs and measures) at commencement, completion and at a suitable timeframe after the conclusion of the project.

Commencement:

Project protocol / plan completion
Survey development and completion
Ethics approval

Completion:

Survey analysis
Education package development
Education delivery
Evaluation of education and resource package

At a suitable timeframe after the conclusion of the project, to measure sustainability:
 A follow up survey to the original respondents at 6 months may be considered to assess longer term benefits

11. Consumer Participation

Detail how the project will consult with consumers throughout its duration.

Given the emphasis on supportive care in this project for those with advanced disease, consumer participation in every stage of this project is vital, in order to deliver on an end-result that is patient focused.

Two consumer representatives will be sourced (through the WCMICS consumer representative panel and/or the RMH consumer representative group) so that each consumer may offer their views and provide support to the other consumer within each project team meeting.

GPs could also be considered ‘consumers’ in this project – GP involvement will be integral, through involvement of each hospital’s GP liaison, as well as other GPs targeted through engagement with Medicare Locals / Primary Health Networks.

PROJECT MANAGEMENT

12. Project Management Strategy

Clearly detail how the project will be managed, including the role of the Project Manager, WCMICS Directorate, any specifically appointed project staff, and the host hospital and/or Project Advisory Group where applicable.

The Project Team will hold the responsibility for delivery of this project as per the project plan and protocol, and within budget and agreed timeline. The Project Manager will report to the Project Team and be responsible for undertaking the project, as outlined in the project plan and protocol, and as directed by the Project Team. The Host Hospital (The Royal Melbourne Hospital) will hold the funds for this project.

13. Project Managers

Name	Position	Telephone	E-mail
Sita Vij	GP Liaison, St V’s	9231 4781	Sita.vij@svha.org.au
Fiona McCormack	GP Liaison, RMH	8387 2161	fiona.mccormack@mh.org.au

14. Project Team

Name	Position	Contact Details	Responsibility
Brian Le	Director, Palliative Care, RMH	9342 7820	Sponsor and Project Lead
Jennifer Philip Tamsin Bryan	Deputy Director, Palliative Medicine, St Vincent's Hospital	9416 0000	Project Lead
Cuong Duong	Upper GI Surgeon, Peter MacCallum Cancer Centre	9656 3750	Project Lead
Sue Hookey	GP Liaison RMH	8387 2256	Project Team
Alexis Butler	GP Liaison PMCC	9656 1111	Project Team
Di Seward	WCMICS Liaison	9656 2780	WCMICS liaison
Wendy Benson	Consumer representative		
Paul Jenkinson	GP representative		

PROJECT BUDGET**15. Changes to Project Budget**

<i>Detail any changes in project budget from project application, specifying reason for any changes.</i>
No changes to project application

16. Budget Outline (attach quotes/supporting evidence as required)

Description	Budget (Inc GST)
0.4EFT RN Gr 3b Y2 including on-costs	\$38,000
Project expenses (stationery, postage, GP rep sitting fees)	\$2000
TOTAL (Inc GST)	\$40,000

Appendix I. Gantt Chart (refer to separate document)