Advance Care Planning/ Advance Health Directive Project

Draft high- level strategies for workstreams 2 and 3: Health professional and community education and awareness raising

The high level strategies outlined in this document are being developed following the recommendations from the My Life My Choice Report and a subsequent Ministerial Expert Panel Report on Advance Health Directives and aim to enable Western Australians to more effectively engage in advance care planning (ACP) and the completion of Advance Health Directives (AHDs) (see end of document for a list of relevant Ministerial Expert Panel recommendations). The strategies outline Western Australia's (WA's) proposed approach to ACP and AHD awareness raising, training and education for health professionals and the community. They are intended to be high level and it is recognised that further research and planning is required to develop a detailed implementation plan(s) in order to determine how the strategies will be resourced and actioned.

Area of focus	Objectives	High level strategy	Possible implementation activities	Related current activity/key stakeholders in WA	Examples of current activity interstate/ international
PROMOTION - *Normalise advance care planning*	• Consumers and healthcare professionals are routinely talking about future healthcare planning, and recognising different cultures and experiences.	• Ensure advance care planning (ACP) and person-centered, values-based care planning is on state and national health and social care agendas to promote discussion and awareness of ACP.	• Identify key state and national committees to provide regular reports and updates to regarding advance care planning activities. • Align, connect and collaborate with activities/initiatives in other states, as well as nationally, to maximise opportunities for promotion for ACP. • Link ACP activities to National Safety and Quality Health Service (NSQHS) Standards wherever relevant (Comprehensive Care Standard 5).		
	• Death is considered a natural process – the conclusion of the life cycle and	• Develop a communication plan to promote the benefits of ACP across all sectors (i.e. Health Services, community	• Collect and share consumers' and healthcare professionals' positive/uplifting stories.	• Build on work already done through ACP Australia.	

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	not a 'failure' of care.	health and social services, residential care facilities, primary care practices, prisons and community groups) using a mix of public relations, networking events and stakeholder engagement.	• Include regular updates of ACP activities and resources in service/ organisation communication channels i.e. newsletters, social media. • Utilise existing groups/ organisations to promote ACP and Advance Health Directives (AHDs) to the community and to health professionals. • Participate in Advance Care Planning Week. • Link in with activities through community networks/groups and local governments. E.g. community centres (e.g. attend seniors sessions), multicultural networks within local governments.	• Palliative Care WA (PCWA) • Cancer Council WA • ACP Consortium via PCWA • Office of the Public Advocate (OPA) community education sessions for Enduring Power of Attorney (EPA), Enduring Power of Guardianship (EPG) and AHDs.	
		• Design and deliver a multi-media awareness campaign – that promotes both ACP and AHDs and differentiates between them.	• Design a broad health promotion campaign building on storylines from the 'You only die once campaign': o with different phases running from 2021 – 2023 • include TV, radio, print, social media advertisements and promotion.	• "You only die once" campaign – PCWA • WA Health End of Life Care Media campaign (2021)	
		• Ensure ACP/AHD is considered and promoted to individuals at all relevant points of contact	• Identify key points of contact to raise ACP/AHD and determine how ACP can be routinely incorporated and how the completion of AHDs		

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		with health/ social services.	can be promoted. For example: ○ Age specific checks ○ Ongoing management of life long conditions i.e. through comprehensive cancer centres. ○ At check-ups with specialists (e.g. oncologist appointments). • Support the development of Consumer Facilitators to support completion of the ACP documents and AHD by patients/residents. Consider coordination from key community organisations.		
RESOURCES – *accessible information and tools to support ACP*	• ACP/AHD resources are consistent, widely available and useful to all.	• Review existing ACP/ AHD resources and tools available in WA to determine what needs to be retained, revised or created.	• Evaluate the uptake of the current ACP e-learning package and revise if appropriate. • Determine the preferred method for education and training materials (i.e. scenario-based training) for different sectors and settings i.e. consider the use of learning videos and simulation-based learning. • Create a centralised location to access all ACP/AHD resources, information regarding ACP education	• E-learning • Education and Training Resource hub being developed by End of Life Care Team. Will house guided learning resources. • Central AHD Register being developed by the ACP/AHD Project Team.	• A clear path to care – SA Health

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			events and resources ordering.		
		• Review Department of Health policies relevant to ACP.	• Review clinical handover policies to ensure advice around ACP/AHD is covered. • Review discharge policies to ensure ACP/AHD are effectively communicated between care settings. Consider the role of My Health Record in achieving this. • Identify similar documentation and combine education resources where appropriate i.e. Goals of Patient Care.	• Training Centre in Subacute Care (TRACS) WA education for Goals of Patient Care. • *TRACS is likely to be aged care focussed. Identify providers for education for health service providers and other providers.	
		• Development of online interactive tool to support people to complete values statement and treatment decisions.	• Finalise revised AHD and central AHD register to determine best approach to the online interactive tool. Ensure value statements are able to be linked to My Health Record.		• Prepare to care in USA • My Values website in Victoria
		• Identify the resource needs of local groups.	• Identify and develop resources and cultural tools (using co-design) to increase ACP access to priority populations including: ○ Aboriginal communities ○ People experiencing disadvantage ○ Culturally and linguistically diverse (CaLD) communities		

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			○ People with mental illness ○ People with disability ○ Older people. • Ensure resources are available in multiple languages. • Ensure resources are available in various formats (e.g. booklets, videos, audio podcasts etc.)		
EDUCATION AND TRAINING – *A prepared workforce and community*	• The healthcare and support staff workforce are skilled in communicating and working with patients and families to make shared decisions about healthcare. • Individuals in WA can develop an advance care plan, no matter where they reside in WA, their ethnicity or socioeconomic status. • ACP interactions are culturally and socially appropriate.	• Implement sustainable systems for the education, training and mentoring of health professionals and support staff to achieve a consistent understanding of ACP competencies.	• Develop the infrastructure to support trained staff to effectively access and deliver ACP and clinical communication training (e.g. access to a portal which provides an overview of all ACP/AHD training available). • Develop standardised training course content. • Recruit skilled staff interested in facilitating training, providing time and support for facilitators to be trained and to deliver training within Health Services in a sustainable way. • Consider the inclusion of ACP in annual training programs delivered by Health Service Provider Education/Development Units. • Maintain a team of advanced communication trainers and	• Education and Training Hub being developed by End of Life Care Team. • Health Professionals Education and Training Framework by End of Life Care Team. • OPA service provider education sessions for EPA, EPG and AHDs.	

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			professional actors (for media campaigns). • Evaluate facilitators and training quality, and support facilitators to ensure sustained quality and skill. • Consider the benefits of introducing ACP clinics.		
		• Health professionals and support staff undertake professional development to acquire the skills needed to engage effectively in ACP.	• Provide readily available evidence-based advance clinical communication training. • Build partnerships and collaborate with education providers to promote availability of and access to training to improve uptake, particularly in primary care. • Investigate opportunities to embed ACP training in mandatory requirements. • Investigate opportunities to assign professional development points and/or key performance indicators (KPIs) to ACP training.	• Palliative and Supportive Care Education (PaSCE) • The Advance Project	
		• Develop a structure on which education providers can build ACP education into curricula, including a tool to facilitate evaluation and assessment.	• Identify and liaise with education providers to review and revise ACP related curricula.	• End of Life Law for Clinicians (ELLC) • Palliative Care Curriculum for Undergraduates (PCC4U)	• Advance Care Planning Aus Education Capability Framework
		• Support the delivery of ACP and clinical communication education locally.	• Support Health Services in the development of infrastructure, processes and policies to maximise the		

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			value of the training and make it easier for Health Services to deliver training locally. • Develop a train-the-trainer programme to train facilitators locally.		
		• Ensure a coordinated approach to the delivery of community ACP workshops and presentations.	• Review current community education and identify any gaps, duplication of efforts and opportunities to increase the spread and uptake. • Create a centralised location to access all ACP/AHD education events and information (as in 'Resources' above).	• PCWA face-to-face workshops • OPA community education sessions.	
		• Develop an engagement strategy to increase ACP/AHD uptake in priority populations including: ○ Aboriginal communities ○ People experiencing disadvantage ○ CALD communities ○ People with mental illness ○ People with disability ○ Older people ○ People in rural, regional and remote areas.	• Identify the need and develop ACP education and training programs and content (using co-design) targeting consumers in priority populations. • Design specific training and education materials to support health professionals to undertake ACP with priority populations including: ○ Aboriginal communities ○ People experiencing disadvantage ○ CaLD communities ○ People with mental illness ○ Older people		

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			○ People in rural, regional and remote areas.		
MONITORING AND EVALUATION – *care is based on evidence and what matters to consumers*	• Measurement and evaluation show the approach to ACP/AHD is meeting the needs of health care professionals and providers.	• Develop a WA ACP Implementation Plan that supports Priority Six of the WA End-of-Life and Palliative Care Strategy 2018–2028. It will include (but not be limited to) – strategies to increase awareness and education regarding ACP and AHDs in WA.	• Establish a Reference Group to guide the development of the implementation plan. • Undertake broad consultations and consider a co-design approach in the development of the implantation plan. • Include a measurement approach and take baseline measures. • Adopt a continuous improvement approach informed by the ongoing collection/supply of Health Service Provider data that measures the completion of AHDs.		• Gold Standard Framework (GSF) Centre in End of Life Care
IMPLEMENTATION – *supporting a coordinated consistent approach to ACP*	• Systems and processes clarify: ○ how ACP can be undertaken across different health and care settings. ○ the roles that different people and organisations can play in the ACP process and provide.	• Establish an 'Office of Advance Care Planning' within WA Health.	• 'Office of ACP' will: ○ Coordinate education activities, and answer consumer enquiries ○ Assist with reviewing completed AHDs to ensure they have been completed as required, from a legal and clinical perspective. ○ Respond to strategies, initiatives and actions at a state and national level that impact on ACP ○ Engage and build relationships with		• Queensland Office of Advance Care Planning • Advance Care Planning: Roles and responsibilities in Advance Care Planning

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			consumers, their families and carers and consumer organisations outside of health that could support the societal and cultural change required. ○ Require close links with Department of Justice (e.g. in relation to Enduring Power of Guardianship).		
	• ACP is systematically incorporated within health services.	• Build systems and processes into existing structures to improve care coordination relating to ACP.	• Health Services work collaboratively with primary and community sectors to improve care coordination around ACP and AHDs. • Health services use quality audits to inform and improve the advance care planning system.		

Recommendation 1 – The scope of a new approach

1.1 A new approach to community awareness and education should encompass and coordinate measures promoting:

- *The concept of 'having the conversation' about serious illness and death;*
- *Advance care planning; and*
- *The statutory instruments.*

Recommendation 2 – Strategic planning

2.1 The State Government should mandate the Department of Health to lead the development and delivery of a community awareness and education strategy.

2.2 The Department of Health should co-design the proposed strategy with relevant government and non-government stakeholders.

Recommendation 3 – Audiences

3.1 The proposed community awareness and education strategy should incorporate initiatives:

- *Addressed to the community as a whole;*
- *Specifically targeting priority groups including older people, people in regional areas, people experiencing disadvantage, Aboriginal people and people from culturally and linguistically diverse communities; and*
- *Targeting individuals at 'key points', including the 75-year-old health check and at diagnosis with a life-limiting condition or neurodegenerative disease.*

3.2 Measures targeting priority groups should be developed and delivered in close collaboration with relevant stakeholders including carers, service providers, the Office of the Public Advocate and advocacy bodies.

Recommendation 4 – Funding

4.1 The proposed community awareness and education strategy should be:

- *Supported by ongoing dedicated funding, to be sought and allocated in line with standard Government budgetary processes; and*
- *Designed to leverage other resourcing opportunities, including those associated with the Commonwealth and the private sector.*

Finding 1: The ability of health professionals to support advance care planning and apply the treatment hierarchy is influenced by a number of structural factors that are not primarily related to education but are addressed in the recommendations of the Joint Standing Committee's report, elsewhere in this report or both. Health services can support individual health professionals to discharge their responsibilities in relation to advance care planning, including adherence to decisions documented in the statutory instruments, by examining relevant processes and policies, particularly in relation to clinical handover and discharge communication.

Recommendation 5 – A new approach to the education of health professionals

5.1 The State Government should mandate the Department of Health to lead the development and delivery of a strategy for educating health professionals about advance care planning, the treatment hierarchy and the statutory instruments.

5.2 The Department of Health should develop and deliver the strategy in partnership with relevant stakeholders including professional bodies, tertiary institutions, aged care providers and Commonwealth agencies.

5.3 The strategy should focus on opportunities to embed consistent information within existing education and training systems including academic curricula and professional development processes.

5.4 The State Government should provide funding to support the development and delivery of the strategy.

Recommendation 6 – Target audiences

6.1 Education for health professionals should:

- Recognise the diversity of roles and educational requirements that exist under the broad umbrella of 'health professionals' and other relevant service providers; and
- Give initial priority to general practitioners, acute sector health professionals and health professionals working with people with life-limiting conditions or neurodegenerative diseases including dementia and/or in aged care.

Recommendation 7 – Structuring the content

7.1 The proposed education strategy for health professionals should consider educational needs across the following stages of the advance care planning process:

- Initiating discussion about advance care planning;
- Assisting patients to make advance care plans, including the statutory instruments; and
- Applying the treatment hierarchy and implementing decisions documented in statutory instruments.