



The District Nurses 2017-18 Pre-Budget Submission to the Australian Government

That most people do not experience death in a place of their choice is evidence of our failing as a society at a time of life that occurs for all of us...

2015-2016 hospice@HOME snapshot

- ☆ hospice@HOME provided care packages for 1,112 clients and their families.
- ☆ 62% of clients who wished to die at home were able to do so.
- ☆ 45% of clients lived in outer regional or remote areas, as compared with 35.3% of the Tasmanian population overall, indicating the success of the hospice@HOME in reaching rural communities.
- ☆ Clients who contacted the after-hours service were significantly less likely to present at an Emergency Department or request an ambulance.
- ☆ Almost half of clients had contact with hospice@HOME social workers, receiving services such as advance care planning, advocacy, counselling, carer support, financial assistance and bereavement support.
- ☆ Clients and carers responding to an internationally-benchmarked survey and follow-up interviews reported high levels of satisfaction with the services they received.
- ☆ 54 service providers across Tasmania (in 2015-16) were contracted by hospice@HOME to provide assistance to clients.
- ☆ Respite care, domestic assistance, personal care and the provision of equipment were most highly valued by clients who responded to a survey.
- ☆ 312 types of equipment were provided, with clients using four items over 69 days on average.
- ☆ A new client management system, Procura, was developed. It was built around the complex needs of the hospice@HOME brokerage model.
- ☆ A 'Just in Case Box' project saw the development of a kit of palliative care medications to be used in the home, with appropriate guidelines and safeguards, and the education of lay carers interested in administering pain relief.

Summary

This submission outlines ways the Australian Government can build on the momentum for change in the way we manage death and dying in Australia that was initiated under the Better Access to Palliative Care (BAPC) program. We suggest that, using the learnings from the Tasmanian hospice@HOME program, the Australian Government and The District Nurses Tasmania work together to develop a cost-effective and sustainable end-of-life bundled model of care for the Australian Government to roll out across Australia. This model will be cost effective and sustainable, reducing costs to the acute care system and meeting future increases in demand for high quality in-home end-of-life care. We believe our proposal will expedite the Productivity Commission's call for 'greater competition, contestability and user choice' in end-of-life services and will firmly place clients at the centre of their care¹.

The proposed model would cut across the aged care, tertiary care, primary health care, and community care systems, complementing other care support streams such as the Commonwealth Home Support Programme (CHSP) and Home Care Packages. It would provide an extra level of support enabling people nearing the end of life to remain at home rather than in a less familiar and more costly acute care setting.

The hospice@HOME program, on which this proposal is based, is a highly successful model of care developed by The District Nurses (TDN) Tasmania for people approaching end of life and their carers. The program has been funded through the Australian Government's Tasmanian Health Assistance Package, as part of the BAPC program.

hospice@HOME offers care packages that coordinate and complement other services available in the community, providing clients with the service mix and level they need to enable 'a good death' at home if they so choose. These care packages allow people to take charge of their end-of-life journey by providing the care and support they need to die with as much dignity and as little pain as possible. **BAPC funding for hospice@HOME will cease in June 2017.**

The benefits of the hospice@HOME program to the Australian aged care system have been:

- Direct savings to the health system through:
 - reduced impost on hospitals
 - reduced use of ambulances
 - a better, more collaborative and more holistic service model
- Providing people approaching end of life and their families with a 'good death' at home
- Providing a model for innovative home-based end of life care²
- Value-adding, both economically and socially, to local communities
- Supporting a network of community based services and strengthening collaborative practice
- Increasing skills of contracted staff and volunteers in palliative and end of life care
- Developing innovative approaches towards care in the community
- Developing a robust research base.

¹ Productivity Commission Issues Paper. *Reforms to Human Services*. December 2016.

² As defined by the Australian Commission on Safety and Quality in Health Care (the ACSQHC), in *Essential elements for a safe and high-quality end-of-life care*, end-of-life care combines the broad set of health and community services that care for the population as they approach the end of life.

TDN is highly aware of the Productivity Commission's 2011 report, *Caring for Older Australians*³, the Australian Government's move towards a market driven system, and the introduction of income testing arrangements. We are also aware of the recent Productivity Commission Issues Paper on *Reforms to Human Services*⁴ and the proposal for a tailored service to 'bundle' services to meet the needs of individuals with life-limiting illness.

We believe that a model of care based on hospice @HOME would provide a viable solution to the issues raised by the Commission. Our proposed model would be highly cost-effective, reducing reliance on the acute system, limiting the need for specialist care involvement in the community, building on the critical role played by GPs, and supporting families in their role as primary carers. We will be making a submission to the Commission in response to its *Reforms to Human Services* Issues Paper, expanding on our ideas outlined in this submission.

We are keen to work with the Australian government to further develop a community-based end-of-life model of care and an implementation process to roll it out across Australia. We offer extensive knowledge gained from the hospice@HOME program, as well as our considerable passion, commitment and expertise, to enable this rollout to be expedited with optimal efficiency and effectiveness. We are keen to work with your government to look at costs and payment arrangements, including how a fair and equitable co-payment arrangement might be implemented.

We look forward to further discussions with your government regarding this proposal and how we can work together to capitalise on the learnings of the hospice@HOME program and implement a world class end of life bundled model of care across Australia.

³ Productivity Commission. *Caring for Older Australians* Inquiry Report. August 2011.

⁴ Productivity Commission Issues Paper. *Reforms to Human Services*. December 2016.

Proposal

The District Nurses Tasmania, to work with the Australian Government to develop a cost-effective and sustainable end-of-life bundled model of care to be rolled out across Australia.

This model will be based on the learnings from the hospice@HOME program, developed by The District Nurses (TDN) Tasmania as part of the Better Access to Palliative Care Program over the past four years. The hospice@HOME program has been demonstrated to deliver considerable savings to the healthcare system, while providing a quality end-of-life experience for clients and carers.

As per the Productivity Commission's Issues Paper on *Reforms to Human Services*⁵, our proposed model will enhance potential for 'greater competition, contestability and user choice in end-of-life care.' It will:

- sit outside the traditional aged care, tertiary health, primary health or community care systems but will coordinate end-of-life services across these systems
- support clients to navigate through systems and services towards their preferred place and circumstances of death
- provide a rapid response with no, or minimal waiting times for clients with complex end-of-life needs and their carers
- cater for clients of all ages who are suffering from a life-limiting illness, providing them with a tailored bundle of care to suit their particular needs
- ensure clients and their carers remain at the centre of service provision and are provided with the support they need to navigate the system and procure the services they want
- offer users greater choice of services and providers, consistently and equitably across regional and state boundaries, and independent of any social or economic parameters
- support the development of expertise in end-of-life care both in new services and in existing services, thus increasing competition and contestability
- provide a comprehensive range of care and support services that are evidence-based and have been well-received by end-of-life clients and their carers
- inform clients about end-of-life care options and promote the use of advance care plans by all clients
- acknowledge and support clients' informal care networks
- entail an appropriate co-payment/financial input from clients
- require a process to procure the services of appropriate fund-holding organisations across Australia to manage care coordination and system navigation on behalf of clients.

While referrals for an end-of-life bundled care package will be channelled from various sources including self-referral, General Practitioners (GPs) will be required to confirm eligibility (i.e. that they would not be surprised if the client dies within 12 months). GPs will also be the clinical lead in decisions regarding care and will be responsible for developing a 'Goals of Care' plan with the client – the client's wishes to be paramount at all times.

⁵ Productivity Commission Issues Paper. *Reforms to Human Services*. December 2016.

Development of the End-of-life model

The model will be developed in three phases:

Phase 1: July 2017-June 2018

- Based on the learnings from the hospice@HOME program and in discussion with the Australian Government, TDN will continue to develop an evidence-based end-of-life bundled model of care, to include a comprehensive set of policies, procedures and protocols; training packages; model service contracts; staffing, IT and infrastructure requirements; and navigation/coordination mechanisms.

Cost: \$250,000

- hospice@HOME packages will continue to be provided in Tasmania up to a limit of 1,000 packages.

Cost: 1,000 packages @ \$2,890 per package, or \$2.89 million per annum⁶

Total cost, Phase 1: \$3.14 million.

Phase 2: July 2018-June 2019

- TDN will work with the Australian Government to develop an Implementation Plan and rollout process for an end-of-life bundled model of care across Australia, to include processes to tender for appropriate fund-holders to manage care coordination and system navigation on behalf of end-of-life clients.

Cost: \$300,000

- hospice@HOME packages will continue to be provided in Tasmania up to a limit of 1,000 packages.

Cost: 1,000 packages @ \$2,890 per package, or \$2.89 million per annum

Total cost, Phase 2: \$3.19 million.

Phase 3: July 2019 and beyond

- TDN will provide consultancy services to organisations across Australia who successfully tender for management of end-of-life bundled packages.

Uncosted.

⁶ Excludes equipment and after-hours service costs which will become the responsibility of the Tasmanian Government.

Introduction

While dying at home used to be a common experience, most Australians now die in hospitals, often in intensive care units. Not only does this strain our hospital and ambulance systems but many people die in an environment and under circumstances that are less than optimal. This institutional approach towards dying is increasingly being questioned. Research shows that approximately 70% of Australians would prefer to die at home – in a familiar place with family by their side.

TDN Tasmania has spent the past four years developing an alternative model of care for people nearing death that enables them to die at home if they so choose. This model, hospice@HOME, has been funded through the Australian Government's Tasmanian Health Assistance Package, as part of the Better Access to Palliative Care (BAPC) program. hospice@HOME allows people to take charge of the end of their life by providing the care and support they need to die with as much dignity and as little pain as possible and in the setting of their choice.

We take great pride in what we have achieved with the hospice@HOME program, which has far exceeded all expectations. While the program has evolved over the course of its operation, the approach we now have in place has met with very high levels of satisfaction from clients and carers, and broad acclaim from the health sector and the community. Not only has it helped clients in their end-of-life journey, but it has also strengthened families and carers and helped build a resilient environment where death is accepted as an inevitable part of life.

hospice@HOME contributes to a much broader reform agenda led by the Australian government to transform the health and community care system and deliver better health outcomes for all Australians. This includes moves to provide a more flexible model of care and develop a consumer led system.

'It wouldn't have entered our heads that we could do it – they gave us the confidence. We did things we never thought we could do.'

'We only had to start thinking about something, and they would organise it.'

We note that demand for end-of-life care in Tasmania is greater than in the rest of Australia due to the State's rapidly ageing population and high rates of chronic disease and cancers.⁷

This submission proposes ways that the Australian Government can build on the momentum for change that has occurred under the BAPC program over the last four years in the way we manage death and dying in Australia. Our vision is to see a viable, sustainable and well-coordinated in-home end of life care option available for all Australians who wish to die at home. This option will complement other options (acute care and residential aged care) and will see primary health care providers, community based services, specialist palliative care services, and clients' formal and informal networks working together to provide compassionate, client-centred care.

⁷ Australian Institute of Health and Welfare, *Palliative Care Services in Australia*, 2013. Canberra 2013.

The District Nurses

The District Nurses (TDN) is a long-established and well-respected part of Tasmania's primary health care landscape. We have grown and changed over the past 120 years, continuously re-evaluating our service delivery to best meet the changing needs of older Tasmanians.

With the opportunities provided through the hospice@HOME program, TDN has expanded its reach statewide. It has developed strong networks both within the public health system and in local communities, where it has brokered services from over 65 different providers. These providers directly employ hundreds of Tasmanians and offer a broad range of services including community nursing, domestic assistance, home help, personal care, transport, equipment, and clinic-based treatment.

TDN understand that no single provider can offer the holistic care necessary for clients and their families during their end of life journey. We have spent considerable effort driving a collaborative approach towards care. Above all, we understand the value of good working relationships with government and have worked tirelessly to foster those relationships.

Links with Australian Government priorities

TDN is confident the hospice@HOME program has not only met all expectations of both the Australian and Tasmanian governments but has far exceeded these expectations. It has proved highly successful during its four-year pilot phase and has been particularly effective in meeting the gaps in services, linking services around the needs of clients and their families, helping to build a high-quality end of life care sector in the community, and reducing the burden on the acute system.

As defined by the Australian Commission on Safety and Quality in Health Care (ACSQHC) end of life care straddles the health and community care systems. As such, there is a broad range of Australian Government policies and priorities that impact end of life care, just a few that we note below.

The operation of the hospice@HOME program is very much in line with the national policy direction for palliative care set out in the Australian Government's document, *National Strategy for Palliative Care 2010: Supporting Australians to Live Well at the End of Life*⁸, and its four goal areas for improving palliative care in Australia: awareness and understanding of death and dying, appropriateness and effectiveness of palliative care, national leadership and governance, and enhanced capacity and capability of all relevant sectors. TDN welcomes the findings of the evaluation of this Strategy and its consideration of how continuous improvement of palliative care in Australia can occur. Likewise, the *National Palliative Care Standards*⁹, developed by Palliative Care Australia, provide a key guiding document.

The national consensus statement produced by the Australian Commission on Safety and Quality in Health Care (the ACSQHC), *Essential elements for a safe and high-quality end-of-life care*¹⁰, is also highly relevant to hospice@HOME. TDN services are very aware of the principles and essential elements of the Consensus Statement and use them as a guide to improving the safety and quality of the end-of-life care that they offer.

⁸ National Palliative Care Strategy 2010. *Supporting Australians to Live Well at the End of Life*. Commonwealth of Australia, 2010.

⁹ Palliative Care Australia. *National Palliative Care Standards*. Fourth Edition. May 2005

¹⁰ Australian Commission on Safety and Quality in Health Care. *Essential elements for a safe and high-quality end-of-life care*. Commonwealth of Australia 2015.

The Productivity Commission's 2011 report, *Caring for Older Australians*¹¹, identified a clear need for reform of the aged care system to make it easier to navigate, to increase consumer choice, to ensure quality and consistency of services, and to enhance system sustainability.

The subsequent *Aged Care Roadmap*¹², *Aged Care Sector Statement of Principles*¹³ and the National Aged Care Alliance's Blueprint, *Enhancing the quality of life of older people through better support and care*¹⁴, all provide consistent messages and future directions for end of life care in Australia. TDN believes that hospice@HOME can provide a key element of these future directions.

The recent Productivity Commission Issues Paper on *Reforms to Human Services*¹⁵ comments specifically on end-of-life care services in Australia and proposes a tailored service to 'bundle' services to meet the needs of individuals with life-limiting illness. The Commission notes that 'high-quality end-of-life care will often involve coordinating diverse services, some of which will be non-medical, across a range of settings.' It acknowledges that most Australians would like to be given the choice to die at home and seeks information on how patients can remain at the centre of service provision at a time when they 'may lack the capacity to make decisions about their end-of-life care.'

TDN notes the issues raised in the Productivity Commission's report and agrees with the intent to 'introduce greater competition, contestability and user choice to end-of-life services'. We believe that a model of care based on hospice @HOME would provide a viable solution to the issues raised by the Commission and will be making a submission to the Commission expanding on the proposal outlined in this submission.

The hospice@HOME Program

The hospice@HOME program was funded through the Australian Government's Tasmanian Health Assistance Package, as part of the BAPC program, initially for three years, with a further one year extension using budget savings. All funding will cease in June 2017.

hospice@HOME provides a 'wrap-around' service model, topping up and complementing existing services and building a package around the specific needs of the client. Services might include nursing, personal care, home help, home maintenance, equipment and respite; or the less traditional areas of child care, gardening, dog-walking, music therapy, art therapy and massage.

hospice@HOME packages intersect seamlessly with the current health system to ensure quality, timely and equitable responsiveness for all clients. Packages can commence immediately with no waiting period. A key aspect of the packages is collaboration with other services. hospice@HOME staff provide care coordination and end-of-life care navigation. These services often commence before the person receiving the package leaves an Acute Care facility.

Referrals proceed either through My Aged Care or, if urgent, through the TasCarePoint portal. hospice@HOME contacts all package recipients on receipt of a referral, as well as the client's GP and the Specialist Palliative Care Service (SPCS) if they have been involved with the client. The GP is required to confirm eligibility for a package on the basis that the client is 'likely to die in the next 12 months'. The GP is deemed the primary provider of care for all the packages unless the GP requests that the SPCS take over the role of primary provider.

¹¹ Productivity Commission. *Caring for Older Australians* Inquiry Report. August 2011.

¹² Aged Care Sector Committee. *Aged Care Roadmap*. March 2016.

¹³ Aged Care Sector *Statement of Principles*. February 2015.

¹⁴ National Aged Care Alliance. *Enhancing the quality of life of older people through better support and care*. NACA Blueprint Series, June 2015.

¹⁵ Productivity Commission Issues Paper. *Reforms to Human Services*. December 2016.

The hospice@HOME program has been demonstrated to deliver considerable savings to the healthcare system. In a report prepared for TDN in December 2015, Quantitative analysis of outcomes of the Better Access to Palliative Care in Tasmania program, KPHealth identified **savings of \$3,975 per client resulting from reduced use of hospital services** (ward beds, Intensive Care Units (ICU) and Emergency Departments(ED) costs). This figure is an underestimate of overall savings as it does not include reduced use of ambulance services by hospice@HOME clients. While these savings would primarily benefit the Tasmanian health system, they also have considerable implications nationally for the Australian Government.

Achievements of the hospice@HOME program

Some of the key achievements of the program are as follows.

Client outcomes

hospice@HOME has been very successful in boosting the number of Tasmanians able to die at home, with 62% of clients who wished to die at home fulfilling this wish in 2015-16. But this is not just about numbers. Clients and their families have been able to have a 'good death' at home, that is respectful, centred on their wishes, and responsive to their needs. hospice@HOME not only provides optimal care to our clients based on national standards but also enhances the resilience of families during their bereavement and grieving processes.

'The staff that came were amazing –they are special people that work in this area. They're not just carers, they are caring.'

Client satisfaction

Internationally benchmarked surveys and an in-depth qualitative evaluation of clients and their families indicated high levels of satisfaction with the program, with most hospice@HOME recipients indicating that it has been very effective in meeting their needs.¹⁶

Efficiency

hospice@HOME has saved the public health system an estimated \$12.4 million over four years and has freed up hospital beds as well as reducing pressure on ambulance services¹⁷. The average hospice@HOME package costs \$39 per day as compared with an Acute Care admission of \$1,645 per day¹⁸.

Partnerships and collaboration

While the integration of the hospice@HOME program into an already complex health and community care system was initially a challenge, TDN has worked hard to build relationships within the sector and to streamline service delivery and processes. hospice@HOME staff have been active participants in a Partners in Palliative Care forum. They have also taken a leading role in the development of a *Collaborative Practice Protocol* that promotes cooperation, mutual respect and a clear understanding of the respective roles of hospice@HOME staff in providing care coordination, and the Tasmanian Health Service's specialist palliative care staff in the delivery of services to community-based clients with end of life care needs.

¹⁶ Press Ganey (2014, 2015) Client Satisfaction Surveys - hospice@HOME Palliative Care Reports (unpublished); Andrews, M., Roach, J., D'Silva, N., Ezzy, S., Hutchison, T., Jarvis, L., & Kelly, L. hospice@HOME Client Satisfaction Report [unpublished] August 2016.

¹⁷ KPHealth, *Quantitative analysis of outcomes of the Better Access to Palliative Care in Tasmania program*, prepared for The District Nurses [unpublished] December 2015.

¹⁸ *ibid.*

Value-adding

hospice@HOME has value-added to the skills base of the network of community services it contracts by up-skilling staff in end-of-life care, advanced care planning and meeting other identified training needs. It has also been instrumental in increasing communication and collaborative practice among these organisations.

Equity

hospice@HOME has promoted equitable access to services, particularly in rural and remote areas, and among population groups who often receive less than optimal services. Current research priorities include investigations into how the program might better meet the palliative care needs of people with dementia, those who have mental health issues, and those who are homeless or at risk of homelessness.

Research

Research has been a high priority of the hospice@HOME program. TDN has been cognisant of the program's pilot nature and the obligation that, as a national priority project, hospice@HOME develops a strong knowledge base for potential application in other jurisdictions in Australia. hospice@HOME has established a robust client information system and research capacity and has taken action to ensure knowledge transfer through the delivery of papers at major conferences, presentations at other forums, the preparation of journal articles, and ad hoc responses to requests for information.

hospice@HOME has been subject to a rigorous evaluation by external researchers appointed by the Australian Government. It has also initiated research into the cost effectiveness of the model in terms of reducing acute-care costs and has employed the international benchmarking organisation, Press Ganey, to conduct in-depth client satisfaction surveys. It has developed a strong internal research capacity and has an evolving research program.

Innovation

While hospice@HOME builds on existent service capacity and resources within communities, several new approaches are being trialled within this model.

Emergency medication kits, known as 'Just in Case' boxes have been initiated and trials of these have commenced. These kits were developed in response to data analysis by TDN that indicated that the most common reasons for admission to an Acute Care setting were symptom management and pain. Detailed guidelines regarding the use of these kits and their safety have been developed in consultation with clinicians and potential users. These kits comply with the Australian and New Zealand Palliative Care Medicine 'Recommendations for Older Australians Living in the Community'. They will be subject to an intensive evaluation process.

Clientranet is a digital tablet-based platform. It has been designed for client and carer use, to provide them with clinical information and to enable communication with family, friends and professionals. This project is being trialed in conjunction with the 'Just in Case' box.

IT capacity

The Procura client management system developed by hospice@HOME has been specifically road-tested and tailored to the requirements of the hospice@HOME service model. This platform could readily be adapted for use by other services.

Economic multiplier

Over a four year period, hospice@HOME has contracted over 65 aged and community service providers, employing over 1,000 people across Tasmania. Wherever possible, local providers have been used and this has increased employment and the flow of capital in communities throughout the state.

The hospice@HOME equipment scheme

The hospice@HOME equipment scheme has been invaluable in assisting people to realise their goal of remaining in their own homes and has been a strong factor in client satisfaction with the service. hospice@HOME maintains 312 different types of equipment, with the greatest demand being for beds, mattresses, seating and mobility aids.

'When we couldn't get mum out of bed, they arrived hours later with nappies and bed pans. When we couldn't manage her in her own bed, within hours they had a hospital bed there.'

In accordance with the BAPC program guidelines, all hospice@HOME equipment will be transferred to the Tasmanian public equipment pool when the BAPC-funded hospice@HOME program ceases at the end of June in 2017. Thereafter, the Tasmanian Government will be responsible for all equipment provided to end-of-life clients. The Tasmanian Government is currently developing a more generic and integrated equipment scheme, which will have revised guidelines and a statewide management system.

To ensure the hospice@HOME equipment continues to be provided in a timely and direct way to end-of-life clients, TDN has proposed that this equipment be delivered in a priority system outside of the current Tasmanian Government Equipment Scheme. We believe this service should be tendered out to a private organisation with specific expertise in this area and the ability to meet competition and contestability requirements in delivering a rapid response to the needs of aged care clients throughout the State.

The hospice@HOME After Hours Service

1800HOSPICE is a free, coordinated, statewide call centre that provides phone advice to clients, carers, and others involved in palliative and end of life care. It also instigates the deployment of local on-call nursing staff or carers. A Palliative Triage Pathway ensures streamlined processes and a rapid response to callers.

Having someone on the phone that you can ask and knows the situation and what's been happening ... that's a great help. I know I can call at any time and they will listen.

Analysis of hospice@HOME client data indicates that contact with the 1800HOSPICE service correlates with a reduction in attendances at hospital emergency departments as well as callouts to the ambulance service.

Prior to the introduction of 1800HOSPICE, afterhours' palliative care support in Tasmania was fragmented and variable depending on the region and locality in which it was sought. hospice@HOME assumed responsibility for the Northern SPCS after hours calls in August 2015 and for the Southern SPCS in June 2016. Before the introduction of hospice@HOME the North West had no palliative after hours' service. The withdrawal of Specialist Palliative Care teams from after-hours' service provision has occurred as a result of a realignment of their functions. As part of this role review,

I was on the phone with you the night dad died. You were a tremendous help to me and supported me to navigate the final hours of Dad's life with dignity and control.

they have also ceased direct service delivery in the community and have taken on a consultancy role to primary health workers. They no longer offer after-hours' services to home-based clients or have any direct contact with them, other than via the client's primary health providers.

The hospice@HOME after hours' service model is built on strong ongoing collaboration with primary care providers and the SPCS and this collaboration is integral to enhancing client's outcomes. Tasmanian clients benefit by having their call managed locally and effectively. We have proposed that the Tasmanian Government funds the after-hours' service and its current governance structures which encompass collaborative arrangements between the Tasmanian Health Service, community based services and hospice@HOME.

Learnings from the hospice@HOME program

Collaboration

TDN initially met with some systemic resistance in introducing the hospice@HOME program in Tasmania due to various historical and cultural issues. The rapid establishment of the program and its integration into the Tasmanian health and human services' system is testimony to our commitment to the hospice@HOME concept.

The establishment of collaborative arrangements across the board – with clinicians, GPs, contracted organisations and other partners in care, and with clients, their carers and their broader networks – has been key to the success of the program. The high levels of satisfaction expressed by clients and carers is testimony to this success. This collaboration is built on extensive knowledge of local networks, providers, circumstances and politics.

For 'partners in care' organisations, hospice@HOME has introduced a Collaborative Protocol which has improved communication, cooperation and collaborative practice among organisations directly involved in clients' care and clinical support.

Brokerage

The development of a brokerage model, with local service providers contracted to provide aspects of the hospice@HOME service package, has been a very positive learning process. While there were initially some issues with levels of staff palliative care knowledge and expertise, and with service quality control and scheduling, these problems have all been overcome and processes are in place to mitigate them. hospice@HOME now provides expert training and advice to contracted services.

The establishment of a provider network of contracted services has been another outcome of the program. Many of these providers work cooperatively rather than competitively, sharing knowledge and resources, and this collaboration is facilitated by hospice@HOME.

Program costs

While hospice@HOME was costed as a pilot model, with generous allowances for establishment and infrastructure set-up, actual service delivery costs fell far short of what was anticipated, allowing for an additional fourth year of service delivery to be implemented within the parameters of the three-year project budget.

The program budget has also included an after-hours service and an equipment scheme, that TDN believes should be supported by state/territory governments in future.

The average per package cost of service delivery is currently \$2,890 (excluding After Hours and Equipment services). TDN is confident that similar programs could be established in other areas of Australia based on this much-reduced cost, plus some additional overhead costs for program administration. A client co-payment, as recommended by the Productivity Commission, could further reduce this cost. TDN's Intellectual Property – for example, our client management system; data collection processes; staffing structure; policies, protocols and procedures; training materials; and research expertise – are readily adaptive for other jurisdictions.

Service mix

TDN has conducted in-depth research with clients to ascertain the types of services that are most beneficial. Carer respite is often a key to maintaining people in their own homes. Allied health services such as social work and physiotherapy, and home help and gardening assistance are also highly valued. Complementary therapies have been very useful for some clients.

TDN has introduced an Emergency Medicine Kit to assist clients and carers with symptom management at the end-of-life. This is currently being evaluated and could have applicability in other areas of Australia.

Staffing

Key to hospice@HOME's success has been the staffing mix, which has evolved over the lifespan of the program. Non-clinical coordinators, social workers and a research team are now essential components of the staff complement. hospice@HOME has attracted a very dedicated and skilled team of workers. TDN can provide advice to other areas on staffing requirements.

Equipment

During its initial establishment, hospice@HOME accessed the generic Tasmanian Government equipment scheme. This proved to be unwieldy, with ongoing problems accessing the right equipment, at the right time and in the right place. A specialised rapid-response scheme was then established through a private provider and this has proved to be very satisfactory.

While TDN believes that state/territory jurisdictions should be responsible for the provision and maintenance of equipment, we believe we now have considerable experience in coordinating this essential part of the hospice@HOME program.

After Hours

Initially there were difficulties with the hospice@HOME after-hours' service, with overlap in some areas of the State with the government's Specialist Palliative Care Service and gaps in other areas where the government did not offer any after-hours' palliative care phone advice. There were also some issues in tendering out the hospice@HOME service to a more generic after-hours' provider.

As the Tasmanian Government no longer provides after hours palliative care advice, hospice@HOME now offers a fully established statewide service directly under the TDN umbrella.

hospice@HOME into the future

TDN wishes to continue to provide in-home end of life care services in Tasmania, and we believe that the model outlined in this proposal would best support clients and their carers. We believe the hospice@HOME program has delivered a 'compassionate community' model, and that the further development of this model will see it as a blueprint for end of life services throughout Australia. The 'compassionate communities' concept is now internationally recognised as innovative best practice.

The Tasmanian hospice@HOME end-of-life model is unique in Australia. We have been particularly successful in reaching rural communities, with 45% of clients living in outer regional or remote areas (as compared with 35.3% of the Tasmanian population overall). While other services in Australia (e.g. Silver Chain WA, SA, QLD, NSW, Hammond Care NSW) provide end-of life care in the community, none have achieved the a similar level of statewide coverage.

We understand this proposal represents a significant funding commitment by the Australian Government in a time of fiscal restraint but we believe it will deliver increasing efficiencies for the aged care and health care systems by reducing the burden of end-of-life care on acute care and ambulance services, while providing a better-quality experience for clients. It would also reduce the need for specialist care involvement in the community, building on the critical role played by GPs, and supporting families in their role as primary carers.

We look forward to further discussions with your government regarding this proposal and how we can work together to capitalise on the learnings of the hospice@HOME program and develop an Australia-wide end of life bundled model of care. We also offer our considerable passion, commitment and expertise to this process.

A husband whose wife had dementia and confusion and was extremely agitated and distressed called the service. She had been doubly incontinent, but would not allow him near her. Our staff member looked up the client's electronic record and contacted one of her 'participants in care' services who had an after-hours facility. The service sent out a carer within 15minutes of the original call. The carer settled the woman and sorted out the issues in the home. If that rapid response had not been implemented, it is likely that the husband would have called an ambulance and they would have ended up in the Emergency Department. This woman later died at home with her family.