NSW Priority Health Care Program

Implementation and Evaluation Plan

June 2001

Integrated Palliative Care Program

Statement of Commitment

We the undersigned agree to participate in the development and operation of the proposed Palliative Care Program as described in the attached Program Proposal:

Karyn McPeake	______________________________ Chief Executive Officer Greater Murray Area Health Service
Dr Joe McGirr	______________________________ Director of Health Service Development Greater Murray Area Health Service
Tony Kolbe	______________________________ Director of Public Health Greater Murray Area Health Service
Keith Fletcher	______________________________ Executive Officer Murrumbidgee Division of General Practice
Keith McDonald	______________________________ Community Health Manager Griffith Community Health Centre
Andrew Mead	______________________________ General Manager Griffith Base Hospital
	______________________________ Ministers Fraternal Griffith
	______________________________ Cancer Patients Assistance Society Griffith

Participants:

GMAHS – Griffith Base Hospital
Griffith Community Health Centre
Health Services Development
Divisions of General Practice – Murrumbidgee
Griffith Nursing Services
Griffith Ministers Fraternal
Griffith Volunteer Support Group

1 Program Aim

- **Aims**

To increase access to an integrated palliative care service for terminally ill people, their carers and families within the Griffith and Carathool Shires;
To achieve a decrease in emergency presentations and inappropriate admissions to Griffith Base Hospital for people who are terminally ill.

- **Objectives**

To increase the number of people who are terminally ill who have an identified case manager.
To increase the number of terminally ill people who are cared for in their home.

- **Evaluation**

The following information will be used to evaluate the program aims & objectives:

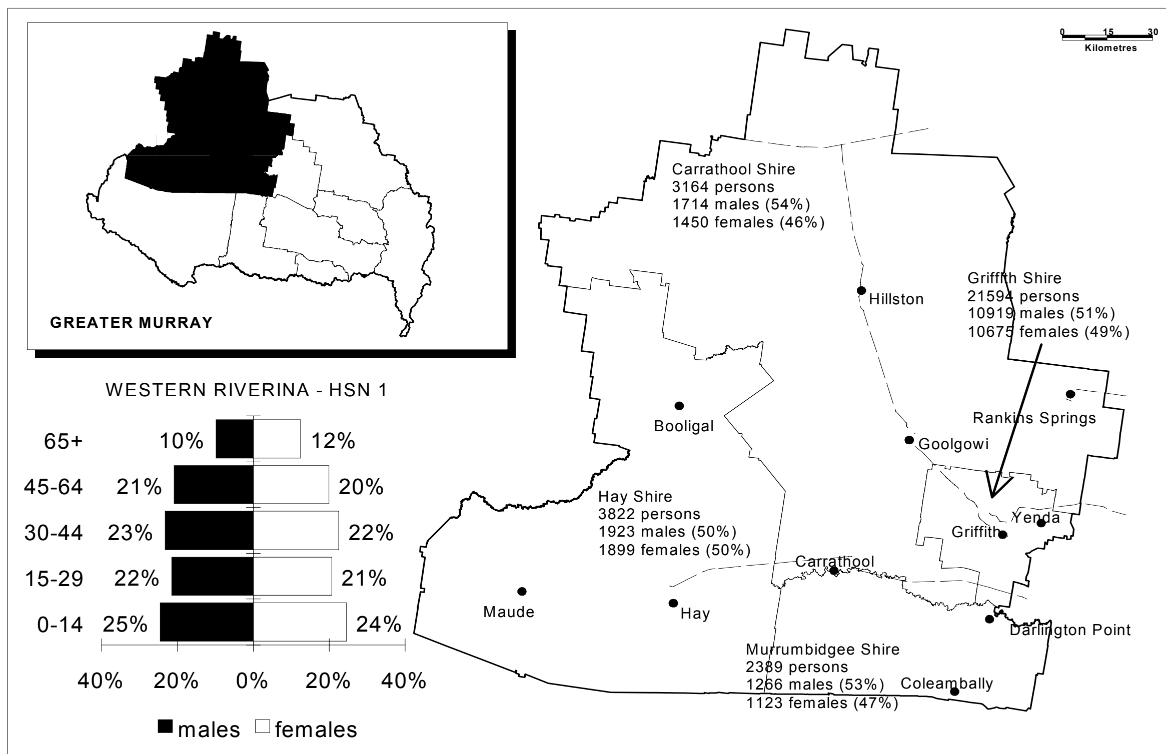
- Annual measurement of hospital admissions; readmissions; emergency presentations; status on discharge; and comparison with baseline data
- Number of people receiving requested terminal care at home and comparison with baseline data.
- Increased use of Enhanced Primary Care items

The Centre for Public Health will be engaged to develop and implement evaluation processes for the program encompassing the NSW Quality Framework principles (1999).

2 Target Population

Figure 1 - Population Characteristics – Western Riverina Network

Source: CDATA 96, Australian Bureau of Statistics



The population age structure for Western Riverina Network is similar to that of NSW and of GMAHS, although there is a higher proportion of children aged 0 – 14 and a lower proportion of women aged 65+.

Table 1: Age and Gender distribution – HSN 1

Source: Census of Population and Housing, 1996 [B03: age by sex, all persons]

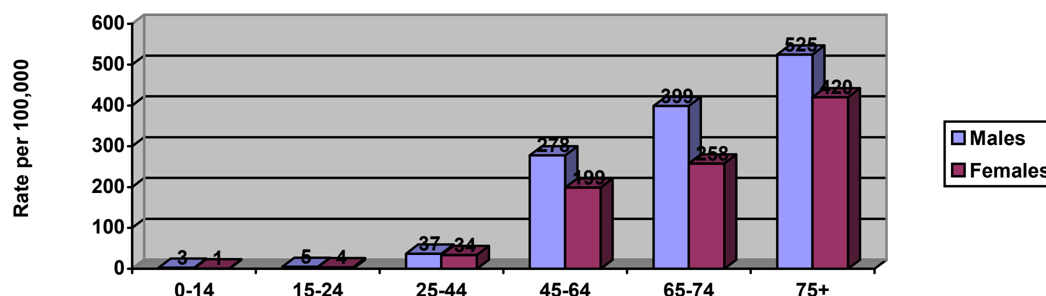
	0-14		15-29		30-44		45-64		65+		Total*		
Locality	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**P**
Carrathool	398	403	328	234	436	356	388	296	157	154	1713	1450	3163
Griffith	2680	2532	2421	2320	2529	2379	2186	2059	1072	1360	10918	10676	21594
Hay	482	463	381	358	425	408	432	408	200	261	1923	1901	3824
Murrumbidgee	316	302	263	214	282	253	288	245	116	105	1268	1119	2387
Western Riverina	**3876**	**3700**	**3393**	**3126**	**3672**	**3396**	**3294**	**3008**	**1545**	**1880**	**15822**	**15145**	**30967**
	25%	**24%**	**22%**	**21%**	**23%**	**22%**	**21%**	**20%**	**10%**	**12%**			
GMAHS	**24%**	**24%**	**21%**	**20%**	**22%**	**22%**	**21%**	**20%**	**11%**	**14%**			
NSW	**22%**	**21%**	**22%**	**21%**	**23%**	**23%**	**21%**	**21%**	**11%**	**14%**			

* Total includes overseas visitors

Data regarding palliative care services in Griffith presently lacks both specificity and completeness. Establishing a system for accurate, comprehensive and timely data collection will be a fundamental focus in this project. Preliminary data for admissions to Griffith Base Hospital over a three month period (October – December 2000) were approximately 33 people out of 1672 (2%). This may be an underestimate due to poor identification of palliative care status on presentation or admission to hospital. A literature review documented within the Sach Report (1998 p.6) indicated that typically 80% of mortality from prolonged terminal illness is caused by cancer, whilst some palliative care services report a prevalence as high as 95%. Therefore in the interim the following epidemiological data on cancer for the GMAHS, whilst accepted as an incomplete proxy, should prove informative.

Cancer is second only to circulatory disease as a major cause of death in the GMAHS, as it is for all of NSW and Australia. In the GMAHS, cancer accounts for approximately 26 per cent of all deaths and around 6 per cent of all hospital admissions. There were a total of 1377 cancer deaths for males and 961 for females registered with the NSW Cancer Registry for the period 1989-93 in the GMAHS. This equates to mortality rates of 172.8 per 100,000 males and 126.0 per 100,000 females. NSW rates were not significantly higher at 214.3 per 100,000 males and 159.6 per 100,000 females.

Figure 1 – Cancer mortality by age and sex – Greater Murray 1989-93
Source: NSW Central Cancer Registry



The rate of mortality for cancer was very low for people aged below 25 years (figure 2). However this rises sharply with age from 25 years onwards. Males had higher rates of mortality from cancer than females in all age groups. This rate difference was most pronounced amongst 65-74 year olds in the GMAHS.

- **Current health service utilisation**

Again specific and accurate data for service utilisation at Griffith Base Hospital and Griffith Community Health Centre is incomplete though data for GMAHS as a whole is available. The hospitalisation rate for all cancer in the GMAHS was 1781.5 per 100,000 males and 1586.4 per 100,000 females. These rates are both lower than the State rates of 1810.4 per 100,000 males and 1828.8 per 100,000 females. The General Manager of Griffith Base Hospital has identified that there are frequent admission to the Emergency Department and the hospital for people who are terminally ill and that there are opportunities to reduce these admission through appropriate community based care and improved patient management.

- **Consumer Involvement in Program design/development & implementation**

The program was developed by an energetic group of service providers and volunteers in Griffith. A Palliative Care Working Group/ Board of Governance is to be formed including key stakeholders plus invited community representatives. The Palliative Care Working Group/ Board of Governance membership is listed in section 8 along with their roles. This Partnership will have the key role of implementation of the program and will be linked to the Primary Care Steering Committee through representation on the committee. A Care Coordinator position will be established to assist the Palliative Care Working Group/ Board of Governance in implementing the project and evaluating the project's success.

- **Proposed Recruitment Strategy**

Clients may be referred either by their GP, palliative care workers and/or Hospitals. The recruitment will be population wide rather than those just admitted to hospital. Special needs populations such as Aboriginal people will be targeted through relevant local strategies.

3 Proposed Intervention

Currently services are provided by the Oncology/ Palliative Care Unit, Community Nursing, Private Nursing Agency, General Practitioners, Griffith Base Hospital, Volunteer Support Network, Palliative Care Team, and the Cancer Patients Assistance Society. These services are all provided within business hours apart from the Private Nursing Agency, Volunteer Support Network, Griffith Base Hospital which are 24 hour services. Community Nurses currently also provide a half day service on weekends.

The proposed program would involve the development of a formal service agreement between Griffith Base Hospital, Community Health, Murrumbidgee Division of GPs, Griffith Nursing Agency, Ministers Fraternal and volunteer groups to provide an integrated case management model of service for Palliative Care. This will include:

- Appointment of a Care Coordinator
- A weekly case management review involving Palliative Care, Community Nurses, Private Nursing agency, GP representatives, Allied Health, and liasing with Emergency Department and Pastoral Care.
- Joint intake options by a Case Management Team.
- Integrated continuous medical records across all services.
- Collection of baseline data, monthly monitoring and evaluation.
- Provision of a 24 hour access number (ie. A local number permanently redirected to a mobile phone number
- Formal GP on call roster after hours (funded by Murrumbidgee Division of GPs) includes attendance for Emergency Department presentations.
- Trained volunteer program with program coordinator.
- Formal agreement with Griffith Base Hospital VMOs for palliative care patient transfer to palliative care team Medical officer on emergency admissions.
- Education programs for Medical Officers, Registered Nurse, Emergency Department Staff, Pastoral Care and Volunteers.

Business hours - the model will be more coordinated with a shared care and integrated medical record. After hours - the clients will be encouraged to ring the local phone number that will be permanently redirected to a mobile phone ‘staffed’ by a nurse on call who would give advice over the phone or call the General Practitioner on call. The GP will take responsibility for providing the home visit or direct the nurse at his discretion. It would be expected that this increase in coordinated care during business hours would result in reduced after hour’s calls although initially there may be an increase due to the Project exposure.

- **Scope**

The project will cover the geographical area of Griffith Local Government Area and Hillston Community.

The project will be based across the following sites: Murrumbidgee Division of GPs, Griffith Base Hospital, Griffith Community Health, Griffith Private Nursing Agency and Hillston Hospital and Community Health Services.

This service model may be transferable to other centres such as Leeton and Narrandera following appropriate evaluation and negotiation with the Murrumbidgee Division of General Practice.

- **Key Delegations**

The Priority Health Care Program Manager will oversee the program.

The Cancer Care Coordinator will be based in Griffith either with the Murrumbidgess Division of General Practice or the GMAHS and provide a support for provider case management of clientele and administrative processes to ensure appropriate implementation of the program. They will be instrumental in ensuring the effective involvement of all the key stakeholders and assist in the data collection and project evaluation. There is a potential for this coordinator position to be extended for a full 3 years to ensure the smooth transition into this integrated model of care.

- **Features**

1. **Flexible models of care** involving accredited volunteers, pastoral care, public and private nursing services and GPs, networking with hospital VMOs and specialist medical services

2. **Demonstrated workforce cooperation** between Griffith Base Hospital, Community Health and private agency for Registered Nurse on call roster

3. **Active inter-agency and community management** of the project through the Palliative Care Working Group/ Board of Governance

4. **Commitment to education** programs for Registered Nurses, Medical Officers and volunteers

5. **Link** with Griffith Base Hospital specialist Oncology clinic and Greater Murray Area Health Services Palliative Care Review Committee

6. **Enhanced equity of access** for non-oncological patients requiring Palliative Care Support.

7. **Integrated medical record** – People attending the Palliative Care Service will have an integrated medical record that will ensure greater continuity of care and more efficient services. Clients will no longer have to repeat their medical history on each presentation to either a new service or to a service that has a high turnover of staff such as Griffith Base Hospital Emergency Department with resident medical officers.

8. **24 hour on-call service** – Staffed by an integrated group including general practitioners, nursing staff and volunteers who are focused on the continuum of care, including bereavement. Client difficulties do not only occur during business hours. A 24-hour on-call service would ensure services are responsive to client needs at all times.

9. **Improved admissions** – With an integrated medical record and 24 hour on-call service, it would be envisaged that admissions would be improved in both efficiency and effectiveness of care.

- **Sustainability**

Through improved case management and after hours support, clients accessing the service will be provided with a smooth transition to existing in-patient services (including

Emergency Department and in-patient beds) and referral to specialist medical support as required as well as improved home-based care. At the end of the three years of the program, the process referral mechanisms for palliative care established by the Care Coordinator would then be in-built into the role of existing Griffith Base Hospital staff.

Additional staff will be required from the following areas:

Priority Health Care Program Manager to oversee all Priority Health Care Programs.

Cancer Care Coordinator based at either the Murrumbidgee Division of GPs, Griffith Base Hospital or the Griffith Community Health Centre.

Nursing staff from Griffith Base Hospital, Community Health and Griffith Private Nursing Agency to provide an after hours telephone advice and call out support service for Palliative Care: -

Monday to Friday – 1800 to 0800 hours

Saturday to Sunday – 1200 to 0800 hours

General Practitioner On-Call service funded by the Murrumbidgee Division of GPs.

This program focuses on a capacity building approach designed to both increase the knowledge and skills of the existing staff and improve GP links. During the program, there will be opportunities to identify likely acute resource savings by all stakeholders. Structural elements such as standardised communication systems with the GPs will be implemented as part of the program aim. This should assist to maintain the clinical integrity of the program. The Care Coordinator will investigate expanding the program to all clients with cancer then possibly consider other chronic diseases should time permit. This effort should aim toward the sustainability of the systems implemented by this program.

4 Program Management

- **Program Milestones**

Operational Milestone	Timeline
Seek community expressions of interest for the Griffith Palliative Care Working Group/ Board of Governance	Feb 2001
Establish 'Steering Committee & Palliative Care Working Group/ Board of Governance', elect executive and draft terms of reference, agenda, and meeting schedule	Feb 2001
Final draft of integrated project proposal	Feb 2001
Initial volunteer and Nursing training	Mar 2001
Establish case review meetings	Mar 2001
Establish routine reporting systems for budget progress, periodic activity and variance analysis	Mar 2001
Finalise project funding	Mar 2001
Print and distribute integrated case file proformas	Mar 2001
Lease vehicle	Mar 2001
Lease PC and IM&T software	Mar 2001

Establish and promote phone number (standard phone permanently redirected to mobile)	Apr 2001
Commence coordinated after-hours on-call service	Apr 2001
Implement monthly review and analysis of project key performance indicators (KPI)	Apr 2001
Draft after hours rosters for Nurses and Medical Officers	Apr 2001
Recruit, select and orientate Care Coordinator	Apr 2001
Media campaign and promotion of project	May 2001
Draft proformas for integrated case files	Jun 2001
Establish volunteer network with a nominated coordinator	Jun 2001
Adopt DVA clinical pathways	Sep 2001
Annual evaluation and report on project performance against KPI	March 2002

- **Organisational Structure**

The Palliative Care Program will be managed by the Working Group with links to the GMAHS Health Service Development Unit and the Priority Health Care Steering Committee (see Figure 3 overleaf). The Primary Health Care Steering Committee and will oversee the project throughout all phases, including design, development, implementation and evaluation.

The Palliative Care Working Group/ Board of Governance will hold monthly meetings. It is expected that its agenda will address ongoing monitoring of proposed key performance indicators, data set completion and evaluation of significant variances within a quality improvement framework, utilising tools such as the Department of Veterans Affairs Clinical Pathways.

Utilisation of a common information management tool through such as the “Medical Director software” to also encourage common medical records.

- **Stakeholders**

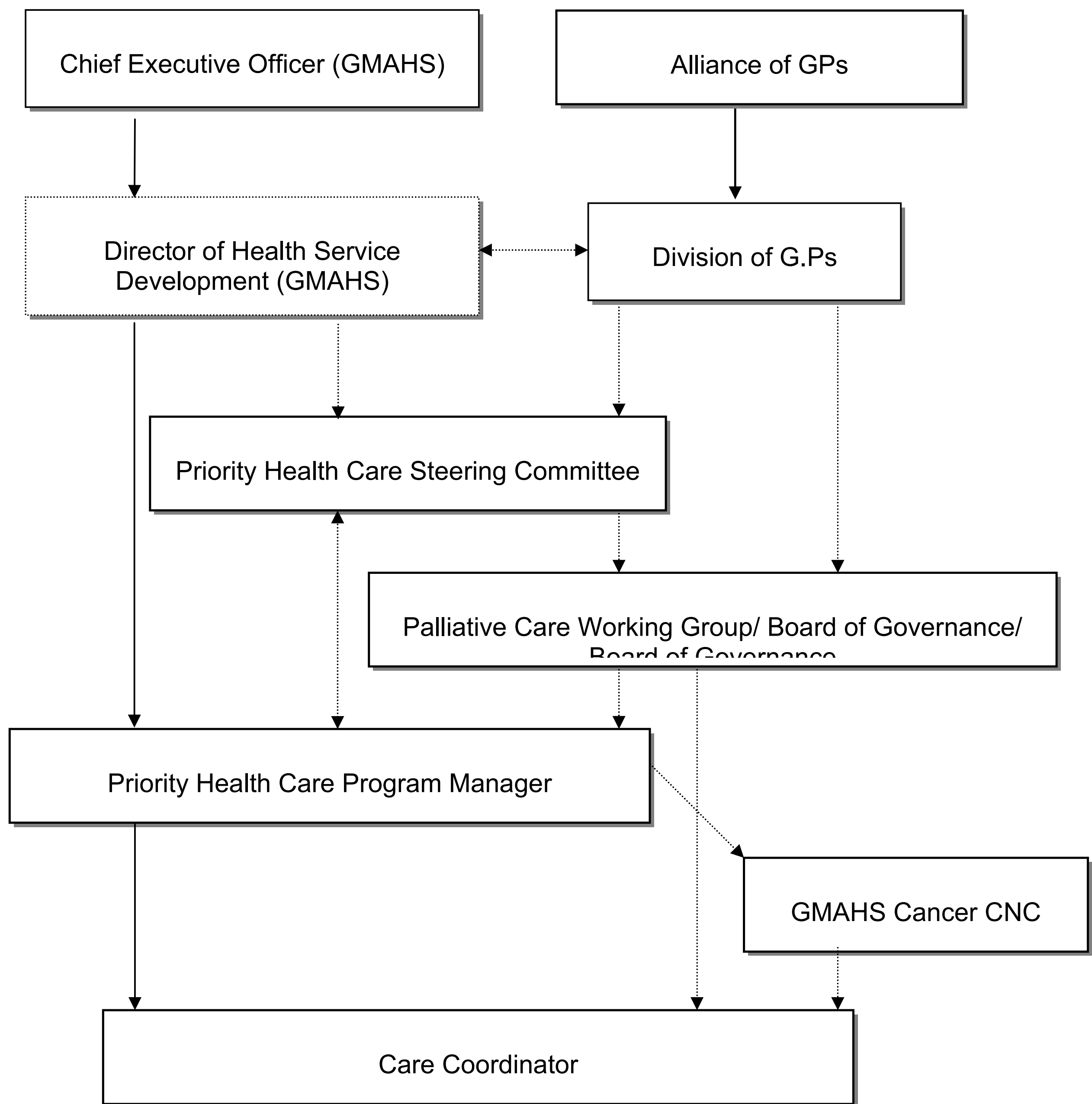
Stakeholder	Role & Responsibility
Care Coordinator	Implementing & coordinating directives of Palliative Care Working Group/ Board of Governance
Ministers Fraternal	Pastoral Care
Volunteer program (Mercy Hospital) Albury	Assisting to develop volunteer model
Cancer Patients Assistance Society	Volunteers
Murrumbidgee Division of GPs	Funding for GP on call roster, administration support, education development of integrated medical records, Steering Committee/ Palliative Care Working Group/ Board of Governance representation, data and evaluation support
Griffith Private Nursing Agency	Registered Nurses for on-call, case management, participation on Committees
Allied Health Personnel	Case Management
Griffith Base Hospital	Clinical Nurse Consultant, Registered Nurses, Emergency Department/RMO support, case management, in-patient beds, specialist medical support, Representative on Steering

	Committee/ Palliative Care Working Group/ Board of Governance, budgetary support
VMO	Specialist advice
Community Health	Registered Nurses, case management, on-call roster, representative on Steering Committee/ Palliative Care Working Group/ Board of Governance
Key community representatives	Representation on Steering Committee/ Palliative Care Working Group/ Board of Governance
Public Health Unit	Evaluation of the project
Dir of Health Services Devt/ CEO	Overall financial responsibility
Priority Health Care Program Manager	Oversee program responsibility
Volunteers	Family and client support

5 Special Needs Groups

Needs of various groups such as the Aboriginal & Torres Strait Islander population, elderly, paediatrics, adolescents, people with multiple chronic conditions & those from NES backgrounds will be addressed at all stages throughout the design, development and implementation of the Integrated Palliative Care program. Culturally appropriate educational materials will be developed and where possible, relevant representations will be invited to provide input into the program.

Figure 3: Organisational structure



6 Program Outcomes

- **Key Program outcomes**

Clinical	▪ Decreased emergency presentations, admissions and length of stay. ▪ Increase in terminal care in the home requests able to be met.
Economic	▪ There is an anticipated decrease in admissions. ▪ Resources will then be reallocated into ambulatory care.
Quality of Life	▪ Improved quality of life for patients with palliative conditions associated with a decrease in acute episodes and increase access to services. ▪ Decrease in active diagnostic and therapeutic interventions.

- **Service Impact**

Hospital Admission Rates	▪ A decrease in admissions of Palliative Care clients
Presentations at ED	▪ A decrease in presentations to Emergency Department of Palliative Care clients. ▪ Reduction in diagnostic interventions in association with Emergency Department presentations
Hospital Length of Stay	▪ A decrease in average length of stay of Palliative Care clients
Community Health	▪ Increased percentage of requests for terminal care at home are met
General Practice	▪ Increase in use of EPC items through case conferencing.

7 Integration with Relevant Initiatives

The program will incorporate elements of the Commonwealth's 'Enhanced Primary Care Package', including the new MBS items, chronic disease self-management & rural health initiatives. Relevant agencies such as nursing homes and hostels will be included in the case management process where appropriate.

The NSW Health Quality Framework[i] is a fundamental aspect of the Palliative Care Program. This program has evidenced based practice at its core thus aiming for optimum effectiveness in service provision. The Centre for Public Health are involved in the evaluation of this program and will ensure that the key performance areas are addressed in the evaluation of the Palliative Care program. These areas are safety, effectiveness, appropriateness, consumer participation, efficiency and access. Consumers will participate throughout the design, development and implementation phases of the

program. The program will be tailored to the specific needs of the GMAHS Network 1 to optimise access for all target clients. Key Stakeholders have signed off on this proposal.

8 Governance

Overall management of the Program will rest with the PHCP Steering Committee consisting of key stakeholders from GPs, medical specialists, consumers, Division of GP representatives, Aboriginal Health representatives, and other relevant health representatives. A Griffith Pallilative Care Working Group/ Board of Governance will also be formed with the following members:

Title	Organisation	Name
Chair	To be nominated by working group	TBA
General Manager of GBH	GMAHS	Andrew Mead
CEO	Murrumbidgee Division of GPs	Keith Fletcher
Director of Nursing – GBH	GMAHS	TBA
Community Health Manager	Network 1 of GMAHS	Keith McDonald
X2 General Practitioner Reps	Murrumbidgee Division of GPs	TBA
Chair of Staff Medical Council	GBH in GMAHS	Dr. Nathan Naganathan
Priority Health Care Program Manager	GMAHS	TBA
X3 nominated community reps	Consumer reps	TBA
Care Coordinator	TBA	Awaiting approval for recruitment

It is expected that the terms of reference of the Griffith Palliative Care Working Group/ Board of Governance will be:

- To ensure transparency and probity to administer pooled funds in order to meet the shared guidelines of the project.
- To assess the progress of the key performance indicators.
- To evaluate the outcomes of the project and make further recommendations.
- To invite ongoing analysis of variance (qualitative)
- To act as a conduit to the community in terms of information dissemination.

Two representatives of the Palliative Care Working Group/ Board of Governance will be invited to sit on the GMAHS Priority Health Care Steering Committee (See section 1).

The following Priority Health Care Program Steering Committee organisational structure below demonstrates the location of the Palliative Care Working Group/ Board of Governance and its relation to the Steering Committee.

22/02/01

Priority Health Care Program Organisational Chart

GMAHS

Priority Health Care Program Steering Committee

Director of Health Service Development
Priority Health Care Program Manager
Division Representatives
General Practitioner Representatives
Clinical Nurse Consultant
Community Health Manager
Consumer Representative
Director of Public Health
Small Hospital Representative
District Hospital Representative
General Managers of Base Hospitals
Manager of Policy & Planning
Program Manager for Aboriginal Health
Program Manager for Aged Care Services
Riverina Medical & Dental Representative
Specialist Representative

Liaison Working Group

Division Representatives from each division
with in the GMAHS
GMAHS representatives

Aboriginal Diabetes Woking Group

Expert Advisors-
Professor David Simmons
Margaret Scott

Director of Health Service Development
Priority Health Care Program Manager
Division Representative
GP Representative
Aboriginal Health Program Manager
Diabetes Clinical Nurse Consultant
Community Health Manager rep
Consumer Representative
Director of Public Health
General Manager rep
Riverina Medical & Dental rep
Specialist Representative

Asthma Management Working Group

Director of Health Service Development
Priority Health Care Program Manager
Division Representative
GP Representative
Asthma Clinical Nurse Consultant
Community Health Manager rep
Consumer Representative
Director of Public Health
General Manager rep
Specialist Representative

Palliative Care Working Group/ Board of Governance

Director of Health Service Development
Priority Health Care Program Manager
EO of Murrumbidgee Division of GPs
GP representatives
Palliative Care Clinical Nurse Consultant
Community Health Manager rep
Nominated Community Representatives
Director of Public Health
General Manager of GBH
GBH Director of Nursing
Chair of Staff Medical Council

9 BUDGET

Specifics	% Cost	Estimate ($) / year	Estimate ($) over 3 yrs
Employee Related			
1/5 part of 1 FTE Program Manager		$12,600	$25,200
superannuation	10	$126	$252
workers compensation	4.5	$567	$1134
annual leave	1.3	$164	$328
sick leave			
Employment of 1 x 0.5 FTE Care Coordinator		$25,000	$98,601
superannuation	10	$3,287	$9,861
workers compensation	4.5	$1,479	$4,437
annual leave	1.3	$427	$1,281
sick leave			
After hours: RN On Call at $13.34/ day		$4,869	$14,607
RN O/T 1.5 at $33.67/hr x 10 hrs / week		$17,509	$105,051
Sub Total		**$66,028**	**$260,752**
Goods & Services : Establishment Costs			
X 1 Computer & equipment lease		$2,000	$6,000
X 1 Desk, chair, whiteboard, filing cabinet		$1,000	
X 1 Mobile telephone		$420	$1,260
Sub Total		**$3,420**	**$7,260**
Goods & Services : Overheads & Administration			
Administrative resources & personnel	5	$1,000	$3,000
Printing		$1,000	$3,000
Phones		$1,500	$4,500
Photocopying		$50	$150
Postage		$50	$150
Computer software		$250	$750
Travel & Accommodation		$5,000	$15,000
Transport		$3,000	$9,000
Training & ongoing mentoring of Care Coordinators		$3,000	$21,000
Training for GPs and other health care workers		$3,000	$5,000
Evaluation through Centre for Public Health		$5,000	$10,000
Sub Total		**$19,850**	**$71,550**
TOTAL		**$89,298**	**$339,562**

11 Footnotes

[i] NSW Department of Health (1999), *A Framework for Managing the Quality of health services in NSW*.

Prepared by Louise McFadden – Acting Priority Health Care Program Manager
In consultation with key stakeholders from the Board of Governance– February 2001.