ADGP Forum 2004

Palliative Care

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What we did

Background

- Sach Report – 1998
- Local Working Party

1. Palliative Care patients were not clearly defined. There was no actual medical record;
2. Palliative Care patients were largely concealed;
3. GP involvement variable and not well coordinated;
4. Specialist services were not well coordinated;
5. Specialist Palliative Care Nurses were overloaded with work, including after-hours;

Background continued:

6. Role of the District and Private Nurse was not acknowledged;
7. No core management, poor communication between medicine/nursing;
8. No available reference material;
9. No dedicated palliative carte beds at Griffith Base Hospital;
10. Patients had no clearly defined pathway to follow after-hours. Subsequently, most ended up in A&E.

Background continued:

Where do you find the money?

- No identified funding stream
- Submission to Commonwealth (Two departments);
- Submission to the State;
- ***Process – Two Years***

Background continued:

Funding:

- Commonwealth – Mental Health & Special Projects Branch
- NSW State Governement – Chronic Disease Management
- Evaluators: Centre for Health Service Development, Wollongong University.

What happened?

Formation of "GAPS" – Griffith Area Palliative Care Service

Key Elements:

- **Evaluation**
- **Governance and Management**
- **Communication**
- **On-Call**
- **Medical Record**
- **Professional Development**
- **Information Management**

Evaluation

- Critical;
- Independent;
- Additional Expertise;
- Guidance;
- Direction;
- Ask the “Tough” questions;
- Tackle the issue of “Generalisability”.

Governance and Management

- Governance – Clinical, Scientific and Organisational;
- Existing funding and payment arrangements, including EPC;
- Agency partnerships and collaboration;
- Role delineation and networking;
- Formal agreement with GBH VMO's for palliative care patient transfer to palliative care team medical officer on emergency admissions.

Communication

- Employment of a capable coordinator;
- Establishment of management group;
- Establishment of weekly clinical case conference meetings;
- 1800 number for patient access;
- Formulation and facilitation of EPC case conferencing;
- Interdisciplinary attendance;
- Newsletter.

On-Call

- Rostered team of GPs providing on-call service (at no charge to the project);
- Over 70% of local GPs participate;
- Rostered team of Registered Nurses providing on-call service (1800 number);
- Service provided at home and upon presentation at the emergency department.

Medical Record

- Patient centred;
- Single record accessible to ALL heralth care providers;
- One single medical record number;
- Patient held;
- Paper based not technology driven;
- Data collection gathered at point of care.

Professional Development

- Weekly case management review involving Palliative Care, Community Nurses, Private Nursing Agency, GP Representatives, Allied Health and Pastoral Care;
- Trained Volunteer Program with program coordinator;
- Education programs for medical officers, registered nurses, ED staff, pastoral care and volunteers.

Information Management

- Introduction and use of the Snapshot/PalCIS palliative care information system as a patient registration and clinical information system;
- Integrated continuous medical records across all services;
- Multidisciplinary care planning;
- Collection of baseline data. Monthly monitoring and evaluation;
- Agency partnerships and collaboration.

What we would do differently

- Very little!
  Caveat: Engagement is central. Key staff turnover can be detrimental;
- Communication strategy with AHS;
- Development of MoU with AHS for security/surety of continued funding;
- Extension of direct coordinator employment.

What happened when funding went away?

- Service continues;
- Continued drive for extension of service;
- “Justifiable Sustainability” (continues to be bottom-line focused);
- Not treated as equal partner (No $ contribution/Reduced Influence)

Health Merry-Go-Round

- Commonwealth/State/AHS Commitment

- Commonwealth "Only like funding pilots"

- State reluctance to fund primary care, "Why doesn't the Commonwealth do it"

- AHS Historically under-funded for Community and Allied Health.

- The fight continues……