An innovative model of collaboration between the Murrumbidgee Division of General Practice & the Greater Murray Area Health Service

ADGP Forum, September 2004

GRIFFITH BY NIGHT

WHAT WAS THE NEED?

1998 a review of Palliative Care services engaged by the GMAHS (The Sach report) identified numerous shortcomings in the Griffith-based service benchmarked to the National Strategy. They included:

- Access for non-oncological Palliative Care was poor.
- Operational links b/w Hospital and Community Nursing teams were poor.
- There was no formal volunteers network.
- There was inadequate data collection which failed to meet National Standards requirement for a minimum data set (MDS).

A local management review subsequently identified:

- Palliative Care diagnoses were not clearly identified in the medical record, and therefore were largely concealed in coding.
- GP involvement was variable and not coordinated. No after-hours service inflated the need for services from the Emergency department.
- Specialist services were not well coordinated.
- In lieu of a dedicated Palliative Care service, the Oncology clinic RNs had assumed this role, including an unauthorized domiciliary capacity after hours. This created substantial professional indemnity and workers' compensation liabilities.
- Role of Community Nursing services (public & private) was poorly acknowledged, and at times inappropriately utilized

NOT TO PANIC…

WHAT DID WE DO ABOUT IT?

In September 1999 a multi-agency working party was convened to review the service and make recommendations to management for alternate service delivery models. Its key tasks included:

- Review the 'Sach Report' analysis and recommendations
- Initial brainstorming & spleen venting sessions
- Benchmarking existing service against like services in Wagga, Albury, Grafton and Lismore.
- Review the National & State strategies & frameworks for Palliative Care.
- Review DVA clinical pathway for Palliative Care.
- Consultation with Palliative Care team, Mercy Albury.
- Matrix key stakeholders and their respective roles with range of contingencies.

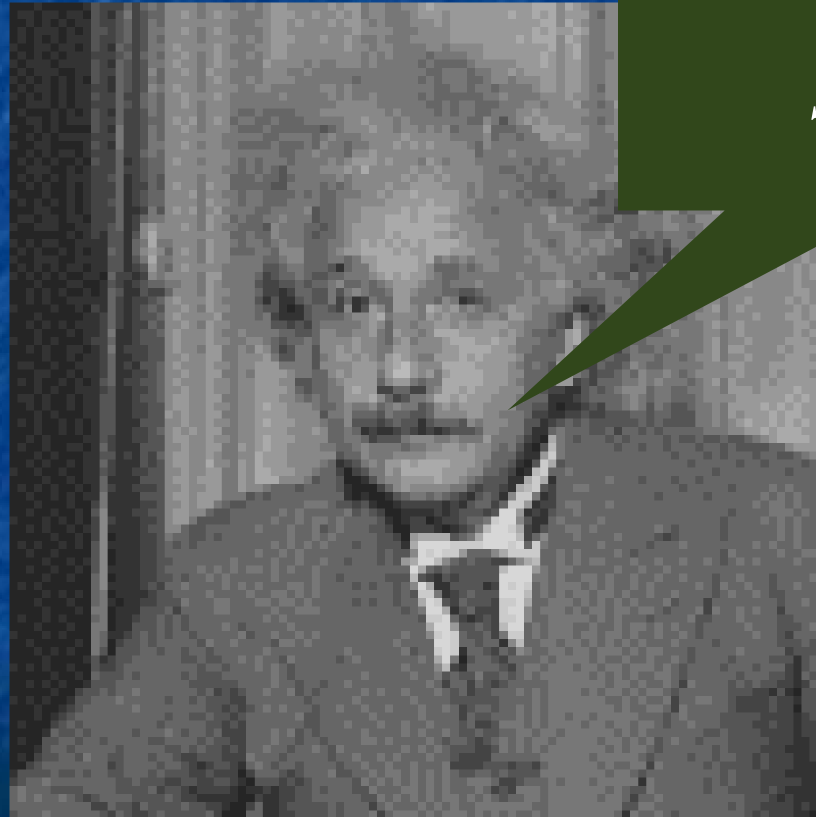
WHAT HAPPENED?

- Alternate models were "tested" using table-top scenarios to consider their implications for continuity of patient care, resourcing, industrial relations, and medico-legal requirements.
- On selecting the preferred model, the working party proposed initially that it be seeded as a 3-year pilot with external evaluation.
- On this recommendation, both the Murrumbidgee Division of General Practice and GMAHS were subsequently successful in submissions for Commonwealth and State grants respectively to proceed with the pilot.

BUT THERE'S MORE!

- The pilot commenced October 2001.
- The pilot demonstrated within its first 18/12:
  - *A 3-fold increase in cases appropriately identified as Palliative Care, with a significantly greater proportion commencing case coordination in the Stable Phase;*
  - *A significant decrease in ED presentations and hospital admissions a/h;*
  - *A 25% reduction in ALOS for acute care admissions*
- The pilot expanded after 12 months to encompass services in small solo GP communities within a 1-hour radius of Griffith.
- Subsequent to a positive external evaluation by the University of Wollongong, the model has now been adopted b/w parties as the *modus operandi* for Palliative Care services in the western Riverina.
- GAPS has now produced a CD-ROM detailing its development.

The key elements of the model have already been described.



It's not rocket science

WHAT WOULD WE DO DIFFERENTLY?

- Increase the focus on value-adding to the existing continuing education programs amongst our current pool of generalist providers (i.e. get Palliative Care in the mainstream curricula).
- Recognise more the need for developing psychosocial services and links with welfare agencies from the outset.
- Establish, formalise and sustain consultative links with a specialist service early.
- Articulate more explicitly the need for good information systems, and broker a commitment from the funders for appropriate investment and development of the same (i.e. Don't assume that that commitment is already there).
- Build from the outset workforce projections into the model and budget build-ups, matched by more explicit contingency plans to respond to expected changes in activity and casemix.

For more information, look for our poster and register for a CD-ROM!

Filling in the
GAPS
GRIFFITH AREA PALLIATIVE CARE SERVICE

EDUCATION
COMMUNICATIONS STRATEGY
ADMINISTRATION
MULTI DISCIPLINARY CARE
BACKGROUND
FUTURE DIRECTION
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BACKGROUND