A palliative and end-of-life model of care for Southern NSW: Overview

South Eastern NSW Primary Health Network (COORDINARE) works with General Practitioners (GPs), other primary and secondary health care providers and hospitals across the South Eastern NSW region to improve and better coordinate care for patients.

COORDINARE has collaborated with the Southern NSW Local Health District, GPs, specialists and other care providers from across our region to develop a proposed model of palliative and end-of-life care that will support integrated and coordinated palliative and end of life care. An overview of the proposed model of care is provided overleaf.

The proposed model of care aims to:

- Support more consistent involvement of GPs in palliative and end-of-life care
- Strengthen the coordination and management of palliative and end-of-life care between GPs, the specialist palliative care service, primary health nurses and other care providers
- Improve outcomes for patients with palliative needs and their families and carers, including greater support for dying at preferred place of choice.

About the proposed model

The proposed model for palliative and end-of-life care in Southern NSW is based on a **stepped care approach**. This approach involves a hierarchy of care and services, from the least to the most intensive, matched to the needs of the individual. While there are three levels within the defined stepped care model, these levels do not operate in silos or as one directional steps, but rather offer a spectrum of services and interventions.

A key component of this model is multidisciplinary care. Multidisciplinary care occurs when professionals from a range of disciplines with different but complementary skills, knowledge and experience work together to deliver comprehensive healthcare aimed at providing the best possible outcome for the physical and psychosocial needs of a patient and their carers. Members and composition of the multidisciplinary team may change as the needs of the patient changes over time.

If you would like to know more about this model of care, please visit www.coordinare.org.au or contact COORDINARE

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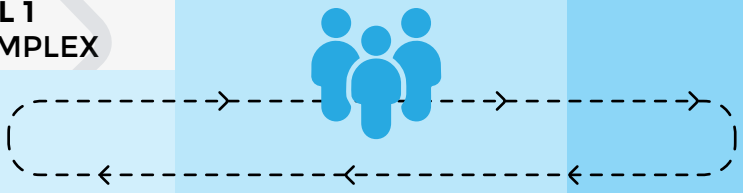
Overview of palliative and end-of-life care for Southern NSW



	LEVEL 1 NON-COMPLEX	LEVEL 2 MODERATE/EPISODIC	LEVEL 3 COMPLEX
OVERVIEW OF PATIENT NEED	Patients with non-complex needs • Largest patient cohort • Mostly non-malignant diagnosis • Most palliative needs met by primary care provider	Generally non-complex needs with intermittent/episodic needs of higher complexity • Sporadic exacerbation of pain and other symptoms • Coping compromised	Unstable patients or ongoing, complex needs • Highly complex physical, psychological and/or social needs which do not respond to standard care protocols • Requires highly individualised care plan Includes most patients at or near end of life.
KEY CARE PROVIDERS	GP +/- advice from specialist palliative care nursing team and/or palliative care medical specialists[2] +/- RACF staff (if applicable) +/- support from GP practice nurse +/- other medical specialists (e.g. oncologist, geriatrician)[3]	As per Level 1, +/-: • Specialist palliative care nursing team (episodic involvement), including afterhours service where available[4] • Nurse practitioners[5] • NSW Ambulance[6] • Inpatient care team (local hospital/Multi Purpose Service)	As per Level 2, +/-: • Specialist palliative care nursing team (regular/active involvement) • Specialist medical consultation[2] • Sydney/ACT specialist palliative care inpatient admission
OVERVIEW OF CARE ARRANGEMENTS	GP is the primary coordinator of care, responsible for early conversations with the patient (including advance care directive, active treatment options and role of palliative care), assessment, early referral to palliative care as appropriate, involvement/support of family/carers, and care coordination and management, including script writing and patient visits. On-call specialist palliative care medical support/advice available.	GP is the primary coordinator of care, responsible for pre-emptive script writing and coordinating care with other key providers. Episodic care from specialist palliative care nursing team and/or nurse practitioner[5] may occur. Agreement on delineation of roles required after referral to specialist nursing team. Equipment Hire program (Mobility Matters) available through LHD palliative care services.	Formalised/documented care arrangement shared between GP, specialist palliative care nursing team, nurse practitioner (as available), specialist palliative care medical provider/s (as available) and other care providers may be required. Coordinator of care to be determined in initial case conference/MDT meeting. May include ongoing case conferencing
KEY SERVICES AVAILABLE	• On-call specialist palliative care advice[7] • NSW Palliative Care After Hours Helpline • Care in the home packages[8] • DecisionAssist telephone advice • Volunteer networks (to relieve • carer stress)	As per Level 1, plus: • Specialist palliative care nursing team – home/residence visits (as required) • NSW Ambulance home/ residence visits (as required) • In-patient admission (local hospital/Multi Purpose Service)	As per Level 2, plus: • Tele/video conferencing with specialist nursing team • Sydney/ACT specialist palliative care inpatient/hospice admission
IMPORTANT PROTOCOLS AND TOOLS	• NSW Health Advance Care Directive • NSW Ambulance Authorised Palliative Care Plan (Paediatric, Adult) • HealthPathways • Therapeutic Guidelines: Palliative Care (Version 4, 2016) • Specialist palliative care nursing service referral form (for Levels 2 and 3) • Decision Assist (palliative care and advance care planning education and advice for aged care staff)		

[1] While clinical symptoms are a key determinant of an increase in care requirements, other factors may inform the decision to initiate higher levels of care and/or referral to the palliative care service, including family/carers' capability and/or willingness to play an active role in care or an identified need to access support services such as the equipment hire program

[2] Type and provider of specialist palliative care medical advice varies across region

[3] Non-palliative care medical specialists are also responsible for early conversations with patients about treatment options and early referral to palliative care

[4] Currently available for Goulburn and surrounding areas, and in Cooma on an as-needs basis

[5] Nurse practitioners may support palliative and end-of-life care in some areas, for example in prescribing medications when a patient is unable to visit GP

[6] NSW Ambulance paramedics are able to provide in-residence palliative care under a NSW Ambulance Authorised Adult Palliative Care Plan

[7] Includes advice from the specialist palliative care nursing team, plus medical advice from various sources

[8] Includes My Aged Care packages and the NSW-wide Palliative Care Home Support Program administered by HammondCare