

Partners in Palliative Care Project Brief: October 2017

Key groups needing to work better together to achieve palliative care outcomes

This project focuses on four groups who need to work in partnership to assist people with a life limiting illness over the last 12-18 months of life:

- Medical specialist in fields such as haematology, oncology, renal, cardiac, respiratory specialties and other chronic diseases.
- General practitioners (GPs).
- Chronic disease support services, including Care Coordination/HARP as part of the Health Independence Program (HIP).
- Specialist palliative care services, including community palliative care services and palliative care consultancy services of public hospitals.

Project context: Victoria's end of life and palliative care framework and "working together"

There are various structural or 'systems' tensions currently impacting on the capacity of Victoria's health sector to deliver high quality palliative care support to all who need it. These include:

- Despite the generally accepted evidence supporting the value of 'early referral' to specialist palliative care services, the capacity of community palliative care services to accept early referrals appears to be limited due to an overall increase in demand for community palliative care. Demand factors include the ageing of the population and the increased length of time people remain living with certain life-limiting illnesses compared to previous years.
- The Victorian Government's end of life and palliative care framework explicitly states that *"It is no longer possible to leave end of life care to (specialist) palliative care providers. Current end of life and palliative care models are unsustainable and will not meet future demand without significant redesign"*. However, the framework doesn't provide any significant detail of what 'significant redesign' might look like, other than to note it *"requires the healthcare, human services, social and community sectors to connect and work together to develop innovative new strategies to deliver care"*.

Practical solutions focus: Models of care and improvements to everyday communication

In addition to exploring new models of care where this might be called for (eg. a different approach to the way community palliative care solicits and responds to 'early referrals'), the project will focus on practical communication and information strategies to assist service providers in their contact with people with a life-limiting illness and their families (eg. assistance with the range of difficult conversations that specialists, GPs and others need to initiate).

Issues the project will address, include:

1. Difficult conversations: Who? When? How?

It is never an easy decision for a health professional to initiate 'difficult conversations' with somebody whose illness has progressed to the point there is the prospect they may die in the next 12-18 months. Between medical specialists, the various aged/community care organisations that might be involved, GPs, family and friends, there is often confusion about who is responsible for having the range of 'difficult conversations' that need to be had and how these should be coordinated.

2. The role of community palliative care services throughout the last 12-18 months of life, including 'early' referrals and processes involved with 'discharge'

In and amongst these difficult conversations, there is often a lack of clarity about the potential role of community palliative care services during the last 12-18 months of life, especially in relation to what services may be available if a referral is made relatively early in a person's disease trajectory and/or when a person is 'discharged' from a community palliative care service due to being assessed as 'stable'. There appears to be varied practice regarding what assistance community palliative care offer the person/family, referring professionals (and other organisations involved) as part of the consideration of an early referral or during and after discharge.

3. The role of Palliative Care Consultancy Services, including in outpatient clinics

Palliative Care Consultancy Services of public hospitals assist people in various ways throughout the last 12-18 months of life, including through outpatient clinics (both specialist palliative care clinics and attendance at other clinics). However, from the perspective of GPs, medical specialists and chronic illness support services, the potential role of palliative care consultancy services is sometimes unclear, including in relation to support with difficult conversations and planning during the 'early referral' phase.

4. The role of chronic illness support services (HIP/HARP)

The role of chronic illness support services such as Care Coordination/HARP through the Health Independence Program (HIP) is not always well understood by medical specialists, GPs and specialist palliative care services. This includes opportunities for HIP/HARP providers to work in cooperation with specialist palliative care services.

5. Help for GP's in their key role throughout the last 12-18 months

For most people, GPs play a key role throughout the last 12-18 months of life. GPs may be required to take a lead role in having various 'difficult conversations', including the idea of considering a palliative approach to care and/or referral to specialist palliative care. Towards the very end of life, GPs often play a critical role in supporting people wishing to die at home or spend as long as possible at home, including with anticipatory prescribing. Previous work undertaken by the Consortium and the North Western Melbourne (and Eastern) Primary Health Networks suggest that there may be ways in which medical specialists and the specialist palliative care system could provide better support to GPs to assist them with their palliative care work.

Project Aims

For GPs, medical specialists, chronic disease support services and specialist palliative care services to have a clear understanding of each other's role and methods for collaborating to deliver high quality person and family centred care for people living with a life-limiting illness in the last 12-18 months of life, including:

- Information and support given to people and their families when palliative care support or a palliative approach is first being considered (prior to specialist palliative care involvement).
- Preferred approaches for referral to community palliative care services and palliative care consultancy services, including options for pre-referral discussion of care needs and exploring options to have these needs met.
- Preferred approaches to ensure appropriate ongoing support is available for people being considered for 'discharge' by community palliative care services.
- Collaborative approaches to care in the last months and weeks of life, including GP involvement in medication management and anticipatory prescribing.

Key Project Tasks

1. Identify key medical specialists in haematology, oncology, renal, cardiac, respiratory specialties and other chronic diseases who service NW Metro residents and encourage their involvement in the project as (1) advisers and suppliers of information and opinions and/or (2) recipients of project information.
2. Identify key personnel of chronic disease support services who service NW Metro residents and encourage their involvement in the project as (1) advisers and suppliers of information and opinions and/or (2) recipients of project information.
 - Note: Key GPs and GP networks, along with key personnel from specialist palliative care services are already known to the project through the Consortium and the involvement of the North Western Melbourne (and Eastern) Primary Health Networks.
3. Establish and implement a sustainable range of communication methods to disseminate and share project related information with GPs, medical specialists, chronic disease support services and specialist palliative care services, throughout and beyond the life of the project.
4. Explore options for improved ways for medical specialists, chronic disease support services and specialist palliative care services to respond to people with early referral needs, including approaches to supporting GPs during this period.
5. Document and make publicly available to all potential referring professionals, the preferred approaches for referral to community palliative care services and palliative care consultancy services, including 'early referrals'.
6. Document and make publicly available the preferred approaches to ensure appropriate ongoing support is available for people being considered for 'discharge' by community palliative care services.
7. Initiate strategies to enhance the effectiveness of communication between specialist palliative care services and GPs to assist GPs with anticipatory prescribing and other care needs in the last months and weeks of life.