A palliative and end-of-life model of care for Illawarra Shoalhaven: 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 Illawarra Shoalhaven Local Health District, GPs, specialists and other care providers from across our region to develop a model of palliative and end-of-life care that will support integrated and coordinated palliative and end of life care. An overview of the model of care is provided overleaf.

The 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 model

The model for palliative and end-of-life care in Illawarra Shoalhaven 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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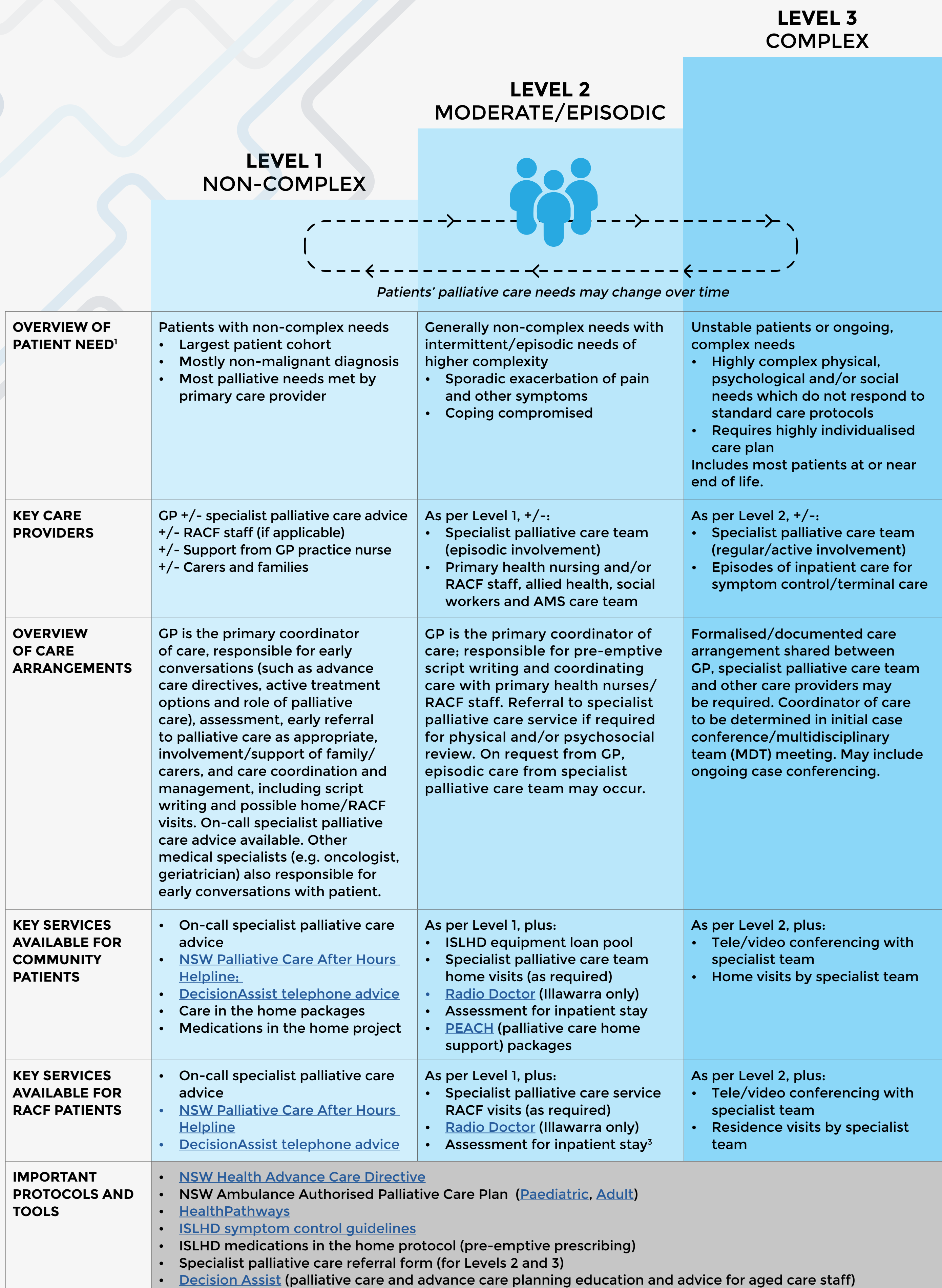
Overview of palliative and end-of-life care for Illawarra Shoalhaven



	LEVEL 1 NON-COMPLEX	LEVEL 2 MODERATE/EPISODIC	LEVEL 3 COMPLEX
OVERVIEW OF PATIENT NEED[1]	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 +/- specialist palliative care advice +/- RACF staff (if applicable) +/- Support from GP practice nurse +/- Carers and families	As per Level 1, +/-: • Specialist palliative care team (episodic involvement) • Primary health nursing and/or RACF staff, allied health, social workers and AMS care team	As per Level 2, +/-: • Specialist palliative care team (regular/active involvement) • Episodes of inpatient care for symptom control/terminal care
OVERVIEW OF CARE ARRANGEMENTS	GP is the primary coordinator of care, responsible for early conversations (such as advance care directives, 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 possible home/RACF visits. On-call specialist palliative care advice available. Other medical specialists (e.g. oncologist, geriatrician) also responsible for early conversations with patient.	GP is the primary coordinator of care; responsible for pre-emptive script writing and coordinating care with primary health nurses/RACF staff. Referral to specialist palliative care service if required for physical and/or psychosocial review. On request from GP, episodic care from specialist palliative care team may occur.	Formalised/documented care arrangement shared between GP, specialist palliative care team and other care providers may be required. Coordinator of care to be determined in initial case conference/multidisciplinary team (MDT) meeting. May include ongoing case conferencing.
KEY SERVICES AVAILABLE FOR COMMUNITY PATIENTS	• On-call specialist palliative care advice • NSW Palliative Care After Hours Helpline: • DecisionAssist telephone advice • Care in the home packages • Medications in the home project	As per Level 1, plus: • ISLHD equipment loan pool • Specialist palliative care team home visits (as required) • Radio Doctor (Illawarra only) • Assessment for inpatient stay • PEACH (palliative care home support) packages	As per Level 2, plus: • Tele/video conferencing with specialist team • Home visits by specialist team
KEY SERVICES AVAILABLE FOR RACF PATIENTS	• On-call specialist palliative care advice • NSW Palliative Care After Hours Helpline • DecisionAssist telephone advice	As per Level 1, plus: • Specialist palliative care service RACF visits (as required) • Radio Doctor (Illawarra only) • Assessment for inpatient stay[3]	As per Level 2, plus: • Tele/video conferencing with specialist team • Residence visits by specialist team
IMPORTANT PROTOCOLS AND TOOLS	• NSW Health Advance Care Directive • NSW Ambulance Authorised Palliative Care Plan (Paediatric, Adult) • HealthPathways • ISLHD symptom control guidelines • ISLHD medications in the home protocol (pre-emptive prescribing) • Specialist palliative care 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 could impact on a decision to initiate higher levels of care and/or referral to the palliative care service, including an identified need to access the ISLHD equipment loan pool or other support services, and family/carers' capability and/or willingness to play an active role in care

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

[3] For management of complex symptoms, respite for carers, or care in the terminal phase.