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Virtual care extends access to palliative care services

A local initiative of Southern NSW Local Health District

July 2023

END OF LIFE AND PALLIATIVE CARE NETWORK

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Southern NSW Palliative Care Service

Overview

Southern NSW Palliative Care Services provide consultative medical, nursing and allied health support to people with complex physical, psychological and social issues and their families. Care is provided across acute and subacute hospital settings and in the patient's home, including residential care facilities. Patients are admitted to acute facilities under the senior medical officer on duty.

Patients in the Southern NSW Local Health District (SNSWLHD) who need care in hospital at the end of life are admitted to general medical wards with rooms that are specially designed to accommodate their needs, and the needs of their family. They are looked after by ward staff, supported by specialist palliative care clinicians. The specialist teams are staffed by nurse practitioners and palliative care nurses who have undertaken training and education specific to the specialty. Some teams include palliative care social workers. Medical services are contracted, and other allied health services are accessible within the district.

Staffing

The district has five nurse-led specialist palliative care teams located in the major regional hubs. These services aim to deliver care in the home. However, when delivered in a hospital, the aim is to deliver this care as close to a person's home as possible. The five palliative care hubs are located in:

- Goulburn
- Queanbeyan
- Cooma
- Bega
- Moruya.

Four of these teams have a nurse practitioner (NP), while Queanbeyan and Cooma share an NP. The nearest hospice is based in the ACT.

Medical cover in Cooma and the Snowy region is provided by an independent specialist operating in a private capacity. The specialist has consulting rights at:

- Cooma Hospital and Health Service
- Bombala Multipurpose Service
- Delegate Multipurpose Service.

The four remaining sites have medical cover provided by a visiting specialist, who also provides consultation via telehealth. The specialist also provides virtual relief for the specialist operating from Cooma.

A shared care model is available with community nursing or Hospital in the Home (HITH). However, this varies across the local health district. HammondCare also provides after hours medical support for medical officers in the LHD.

Table 1: A summary of palliative care support services that SNSWLHD staff can access

Service	Business hours	After hours	Location(s)
NSW Ambulance updated protocols for paramedics for palliative care patients	Yes	Yes	NSW
General practitioner and primary care provider care	Yes	Variable	LHD
Out of Hospital Care and End of Life packages	Yes	Yes	LHD
Palliative care volunteers	Yes	No	Cooma, Queanbeyan, Eurobodalla, Bega and Goulburn
Bereavement services	Yes	No	LHD
Allied health	Yes	No	LHD – varying level of access
Palliative care equipment	Yes	No	LHD
Shared care model with community and Hospital in the Home nurses	Yes	Yes	Used for all care including weekends
Weekend nursing support escalation pathway	No	Yes	Used for weekend care
Nurse-led specialist palliative care			
Non-admitted clinics and community care, including residential aged care facilities	Yes	No	LHD
In-reach, in-hospital inpatient (nurse practitioner and clinical nurse specialist grade 2)	Yes	No	Queanbeyan, Yass, Goulburn, Crookwell, Braidwood, Cooma, Moruya, Batemans Bay, Bega, Pambula
Residential aged care facilities needs rounding	Yes	No	LHD

HammondCare			
On-call (phone and virtual) palliative care medical specialist	Yes	Yes	LHD
Medical specialist site visit	Yes	No	Queanbeyan, Eurobodalla, Bega Valley, Goulburn
Medical specialist weekly multidisciplinary team (virtual) with palliative care specialist nurse team	Yes	No	Queanbeyan, Goulburn, Eurobodalla, Bega Valley

Referrals

Patients in the community are referred to SNSWLHD specialist palliative care services via the Community Health Central Intake Service. A generic community health referral form is used. Admitted patients are referred to palliative care services using an eReferral within the electronic medical record (eMR).

Referrals are accepted from Monday to Friday by the palliative care specialist nurses. Timing of the initial contact is aligned with The Australian Palliative Care Outcomes Collaboration (PCOC) benchmarking principles and facilitated via an informal or formalised triaging tool.

The system for triaging referrals varies from service to service. However, the target PCOC benchmark for referrals to palliative care specialist services is that 90% of patients have their care started within two days of them being ready for care.

The time from the date of referral to the date of first contact with the client reflects responsiveness of palliative care services to patient needs. Access to palliative care is prioritised on patient need and waiting lists are not kept for palliative care referrals.

Performance

During 2021-22, almost half (42%) of SNSWLHD's palliative care clinical service contacts were delivered using videoconferencing or telephone.

Between 2020-21 and 2021-22, the use of videoconferencing by the palliative care program increased by 400%, supported by the adoption of myVirtualCare.

Benefits of the model

Staff experience

Staff have embraced the use of virtual care and identified many advantages, including the following:

- The use of the technology gives clinicians and patients a choice (where clinically appropriate) on how patients wish to receive their care.

- Virtual care can support timely access to the patient (when required).
- Virtual care reduces the necessity to travel long distances.
- Although this is not always appropriate, virtual care can be useful to accommodate patient/clinician schedules, supporting flexible work practices and retention of staff.
- There is capacity to involve all care providers in patient consultations and multidisciplinary team meetings. This enhances communication, clinician satisfaction and patient outcomes.
- Staff were provided with education, training and the equipment required to support implementation of virtual care.

Positive feedback

As noted by a palliative care clinical nurse specialist based in the Eurobodalla Shire, myVirtualCare enables patients and their families to have access to specialist consultations in a timely manner.

“Previously our patients would wait up to a month for limited specialist appointments,” the nurse says. “With the use of myVirtualCare we can be linked with patients within 24 hours or as required on a regular basis.

“myVirtualCare also allows for greater patient-centred care by involving external service providers, enabling them to remain informed. I think it has supported families and carers of patients by providing reassurance that they are supported as a whole.”

Clinical outcomes

Virtual care can enhance clinical outcomes for patients in these ways.

- Care can be delivered to the patient promptly and in their home via a consult with the required clinicians. This enables the patient needing to go emergency department.
- Family and carers can be involved as partners in the care discussion and decisions.
- The ability to involve the patient's general practitioner (GP) in the consultation has been of great benefit to the patient's care and ongoing management of their symptoms.

Improved patient experience

As well as improving clinical outcomes, the use of virtual care can enhance the patient’s experience. Patients and carers have accepted and use virtual care for the following reasons.

- Many patients don’t like leaving home to attend appointments.
- Sometimes the appointment can be a significant distance from home, so the patient prefers care to be brought to them.
- Cost savings include parking and transport. Virtual care also reduces the burden and loss of wages for carers who are able to participate virtually.
- It can be more convenient and less disruptive, especially when juggling family needs, such as education, work commitments and care for other family members.
- Virtual care enables the patient’s family and carers to be involved in the consultation during times they are unable to attend in person.

Patient story

A patient with limited mobility required a medication and care plan review that needed a registered nurse to attend and involved a palliative care doctor who was offsite.

With minimal setup, the nurse established a videoconference with the doctor using myVirtualCare. The patient's oncologist was also linked into the virtual consultation for an update. The doctors were able to review treatment collaboratively. As a result, they reached an agreement within an hour that aligned with the patient's oncology and palliative care goals.

Cost advantages

- Equipment is shared among clinical teams, reducing the number of devices and associated storage and charging stations required.
- Unnecessary clinician travel time is avoided when virtual care is used appropriately.

What tips do you have for others?

- Discuss the option of virtual care to supplement existing in-person care with the patient, their family and carers.
- Health staff should work as a team to understand and unpack challenges regularly, while also celebrating the value virtual care brings to the service.
- Reach out early to access support. The Agency for Clinical Innovation (ACI) and your local Virtual Care Manager can provide initial and ongoing education and support in how to best use the technology.
- Virtual care needs to be incorporated into the orientation for new staff and reinforced at all levels of the organisation.
- Continue reinforcing the importance of recording the service events in eMR for all occasions of service and the modality used. This ensures non-admitted patient data accurately reflects the activities of the service.
- When involving a GP in patient consultations or multidisciplinary team meetings, ensure they are booked in advance to enable them to attend and attract payment from Medicare.
- From the beginning of the service, plan to capture district and service-specific patient experience measures. This will ensure that you collect real-time feedback from patients on their experience of care. This is powerful in supporting a patient-centred approach using the feedback to adjust service offerings and support the adoption of virtual care.

Next steps

There is the potential to increase use of virtual care in particular for:

- nurse-led consultation
- general practitioner involvement in consultations
- future development of an after-hours model.

To this end, the LHD is looking to increase the number of clinicians offering virtual care to patients, when clinically appropriate. It also aims to increase the use of videoconferencing in place of telephone consultations and reviews.

Other steps include:

- Assessing whether remote patient monitoring can be used to enable patients to stay at home where possible and clinically appropriate.
- Increasing technological involvement of family and carers as appropriate so they remain informed and prepared for when changes in the patient's condition occur.
- The SNSWLHD palliative care team taking part in a GoShare trial being led by the ACI where patient and carer information is sent electronically in a bundle containing resources in a variety of formats.
- Further training and support to build confidence of clinicians to be led by the ACI and the SNSWLHD Virtual Care Manager.

Appendix

Alignment with the Clinical Principles for End of Life and Palliative Care Guideline

Key action area		Evidence
1. Screening and identification	✓	Patients in the community are referred to SNSWLHD specialist palliative care services via the Community Health Central Intake Service using a generic community health referral form. Admitted patients are referred to palliative care services using an eReferral within eMR. Time from the date of referral to the date of first contact with the client is based on assessed need.
2. Triage	✓	Timing of the initial palliative care contact is based on PCOC benchmarking principles and facilitated via an informal or more formalised triaging process (i.e. use of a specific triaging tool). The system for triaging referrals varies from service to service. However, the target PCOC benchmark for referrals to palliative care specialist services is that 90% of patients have their care started within two days when ready for care.
3. Comprehensive assessment	✓	SNSWLHD specialist palliative care services provide consultative medical, nursing and allied health support to patients with complex physical, psychological and social issues and their families. Care is provided across acute and subacute hospital settings and in the patient's home, including residential care facilities. This assessment can be conducted using virtual modalities and include a GP, carer and other care provider participation with the option of store and forward as needed.
4. Care planning	✓	The district has five nurse-led specialist palliative care teams located in the major regional hubs across the district. These services aim to deliver care in the home with the option to involve carers or other care providers virtually. When in a hospital, the services aim to deliver this care as close to home as possible. Virtual modalities can also be used to support multidisciplinary team meetings and case discussions.
5. Open and respectful communication	✓	Virtual care is used in a variety of modalities to support the delivery of palliative care services across the district. Virtual care can be delivered through various platforms including telephone, myVirtualCare and PEXIP. Clinicians discuss how care can be provided including use of virtual care. In many cases patient journeys include a hybrid approach mixing both virtual care and

		in-person appointments. Patients are offered virtual care and given the choice where clinically appropriate. Patients can change the way they wish to receive their care at any time. Information is provided to the patient and their carers about virtual care and how to use the technology. Patients are informed when clinical photos and results are sent electronically (store and forward) to other members of their care team.
6. Symptom management	✓	HammondCare provides specialist palliative care medical input to support care delivery in SNSWLHD. This includes participating in consultations with patients in their home or other care setting where carers and other providers have the option to attend virtually, participating in multidisciplinary team meetings (in-hours) and after-hours support and medication management. Clinicians can take photos and send emails using virtual modalities to seek specialist advice. This is known as store and forward.
7. 24/7 access to support	✓	If required, medical officer support is available to provide advice to nursing staff after hours.
8. Place of death	✓	The district aims to deliver palliative care services in the home, where virtual care is an enabler of this model. This also facilitates the patient's wishes where they have identified that home is their preferred place of death. It enables any family unable to visit in-person to use technology to connect.
9. Grief and bereavement support	✓	Specialist bereavement services are being established in the district. However, generalist bereavement support is available.

Acknowledgements

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