General practice palliative care- what is and what can be….

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Palliative care is…

an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

World Health Organisation 2004.

General Practice is….

the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities.

Source Royal Australian College of General Practitioners. The scope of General Practice. 1973

…. “the only difference between standard general practice and palliative care is the intense nature of the problem and a short time frame.” Mitchell Palliat Med 2002

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General Practitioners (GPs)

Primary care practitioners who see people unreferred.

Care characterised by:

Longitudinal care

Comprehensive care

Privately owned clinics:

GPs either owners or employers

Remuneration:

- Per patient
- Structured care of chronic illness

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Nature of work

All GPs:

Common self limiting conditions
Chronic physical illness
(eg hypertension, diabetes, asthma, OA)
Mental health - anxiety, depression, bi-polar, schizophrenia
Situational crises-
Prevention
Health promotion

Rural/ Regional

Procedural and major emergency
Obstetrics
Inpatient

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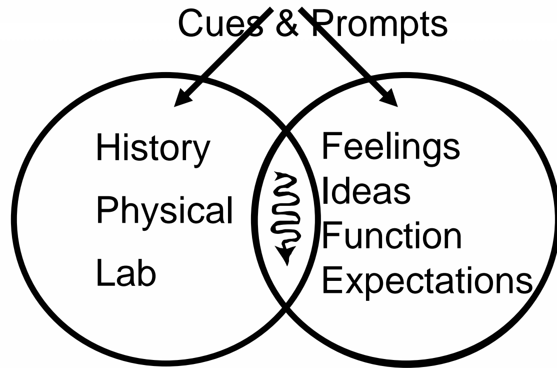
General Practice and Palliative Care

"The specific nature of palliative care allows GPs to showcase the strength of a generalist approach. This ….. manifests as a creative tension between evidence-based biomedical care, a patient-centred approach and the more traditional role of 'healer'. GPs think and reflect around patient stories, rather than the abstraction of data to achieve best practice care."

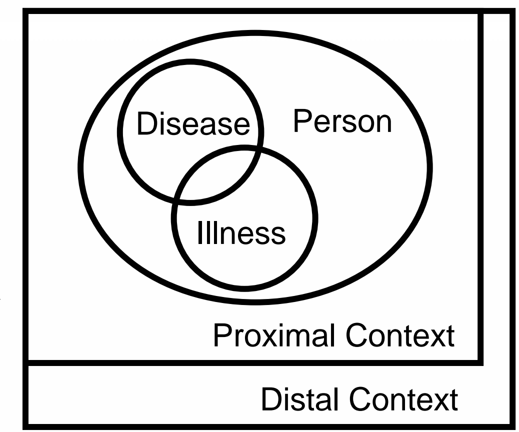
Mercer P. in press

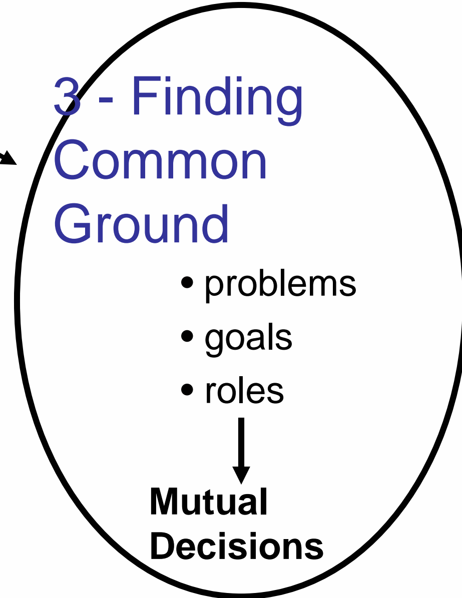
The Patient-Centered Clinical Method
Six Interactive Components

1 - Exploring Both Disease and Illness Experience



2 - Understanding The Whole Person



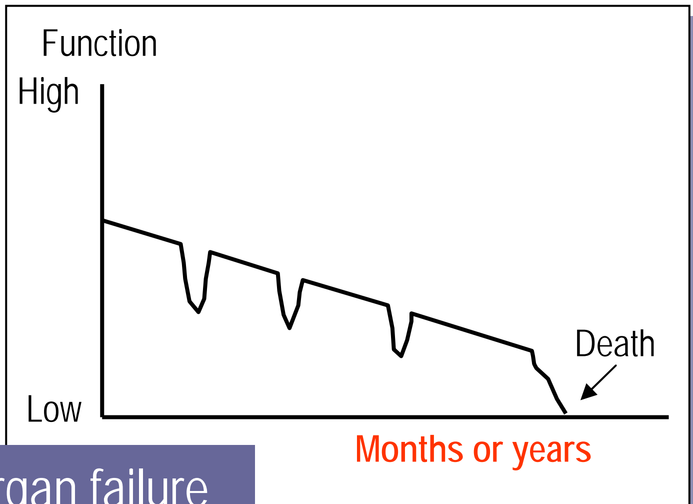


4 - Incorporating Prevention and Health Promotion

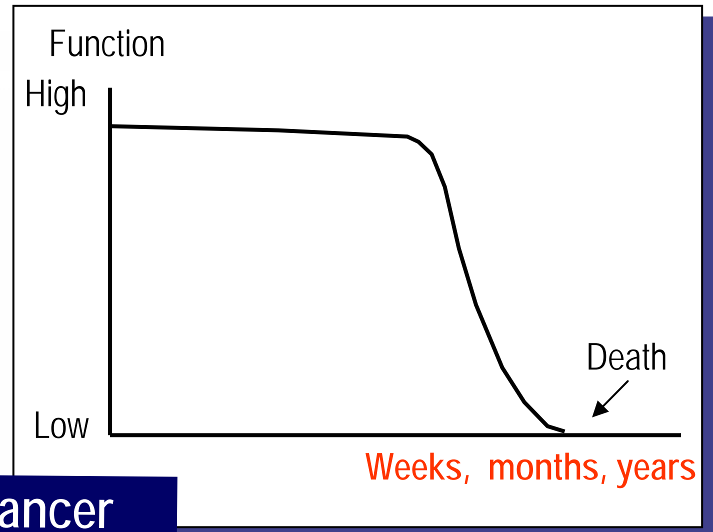
6 - Being Realistic

5 - Enhancing the Patient-Physician Relationship

Who needs palliative care?



Organ failure

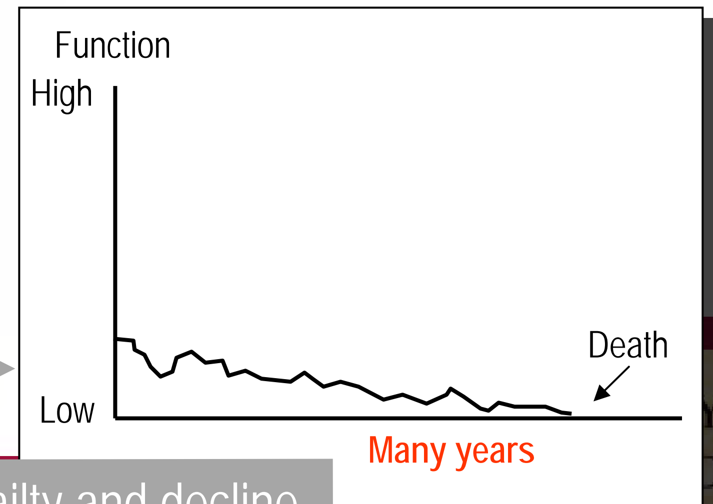


Cancer

GP has 20 deaths per list of 2000 patients per year

2

Acute

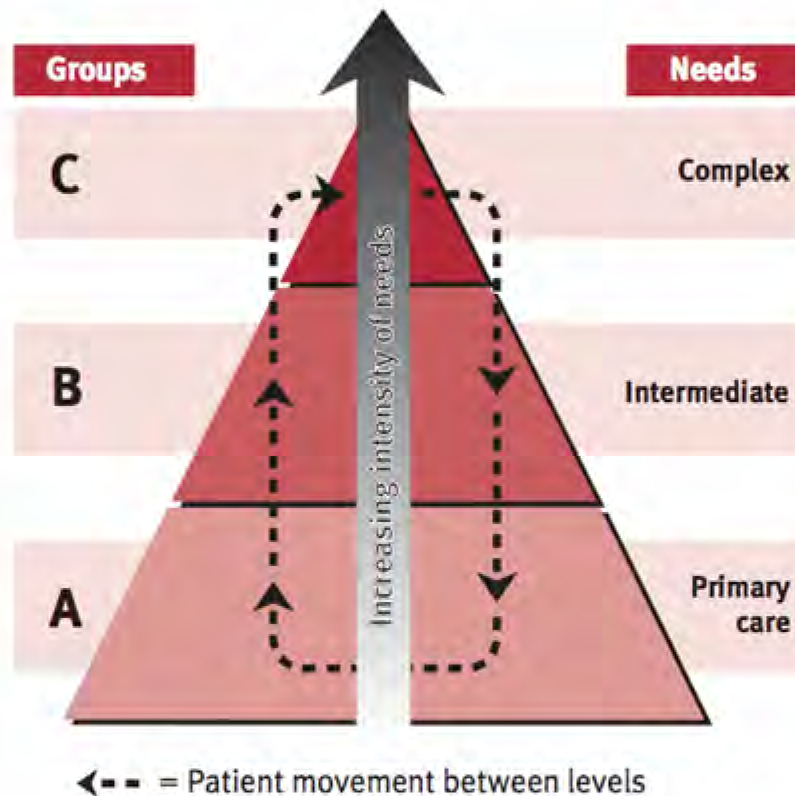


Dementia, frailty and decline

Slide – Thomas K. 200

Where is, and where should palliative care be delivered?

PCA model of palliative care delivery



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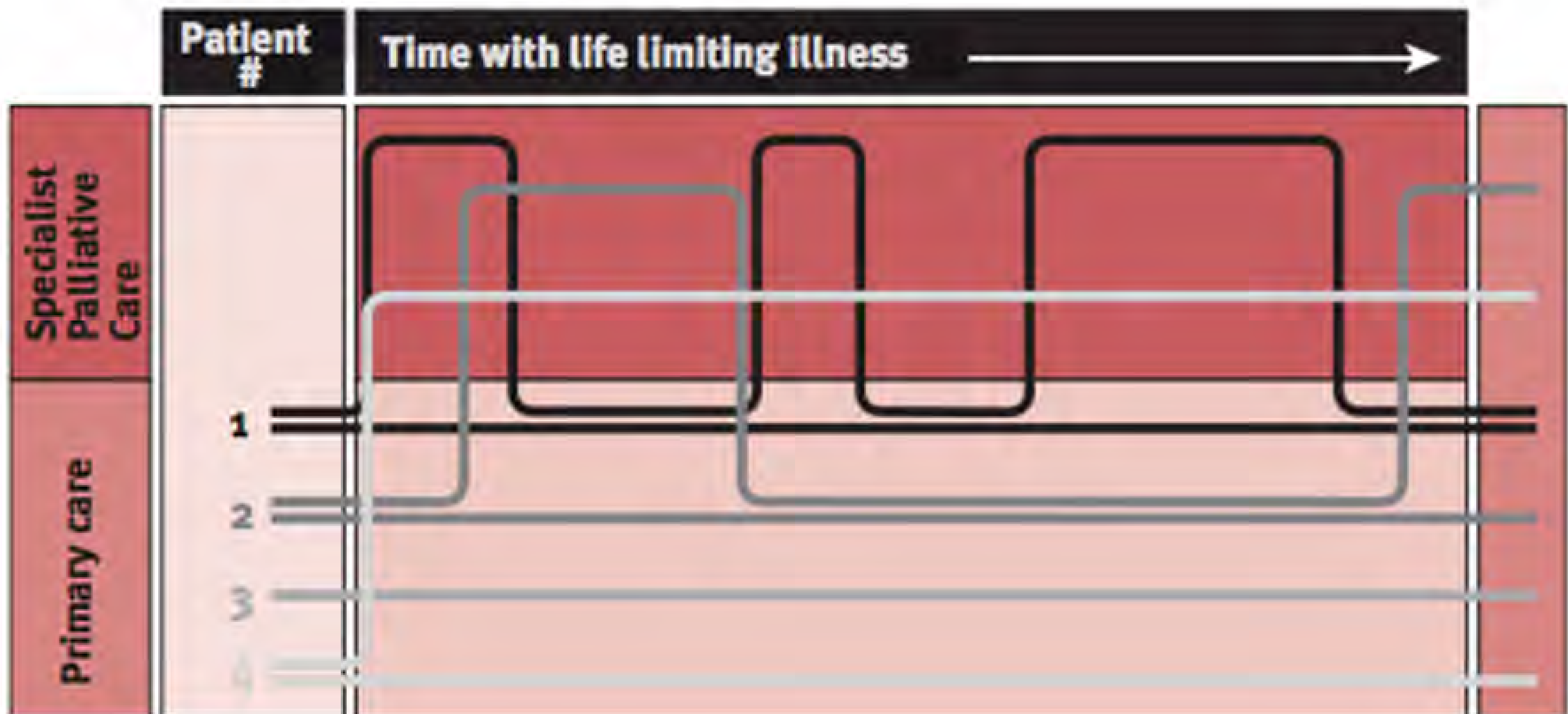
Source: PCA 2005

Illness trajectories and where care is delivered



Source PCA 2005

Needs

High

Low

Needs of patient, family/carer or service provider

Resources level

Where

Primary Care providers. Make referrals to specialist palliative care services based on needs and are supported in their role.

Specialist Palliative Care Service Resource Level 3
Has formal links with level 2 services and responsibility for a designated population

Metropolitan & Large Regional Centres

Specialist Palliative Care Service Resource Level 2
Has formal links with level 3 and level 1 services and responsibility for a designated population

Metropolitan & Regional Centres

Specialist Palliative Care Service Resource Level 1
Has formal links with level 2 and level 3 services and shares responsibility for a designated subpopulation of Level 2 services

Metropolitan

Small towns

Primary Care Providers
Has relationship with designated specialist palliative care service, makes referrals according to level of need. Has education to provide care with palliative approach

Everywhere

Community & Public Health Initiatives & Participation

Key: = Referral = Support = Participation = Interaction

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Challenges

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PCA planning documents indicate:

1. Primary care (general practice) is central to delivering palliative care

2. Primary care (general practice) should be providing clinical palliative care as a matter of course

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3. Specialist palliative care services should be supporting primary care (general practice) as a matter of course.

Encouraging participation

Developing skills

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The characteristics of GPs who DO and DO NOT practice palliative care

Rhee et al J Pall Med 11: 980-985

Postal survey of Urban GPs in two areas of Sydney.

269 responses (61.9%)

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75% GPs willing to take on PC

25% don’t perform PC:

Younger 48yrs vs 52yrs ($p = 0.004$)

Part time 34 vs 41 hrs per wk ($p<0.001$)

Overseas trained 41% vs 25% ($p = 0.019$)

Employees rather than practice principals 50% vs 13% ($p<0.001$)

Female (trend) 52% vs 39% ($p = 0.052$)

Source- Rhee et al J Pall Med 11: 980-985.

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Barriers to providing PC

(all significant)

Don't do home visits	75% vs 55%
Family commitments	72% vs 49%
Personal commitments	68% vs 42%
Lack of knowledge	48% vs 21%
Emotional reasons	16% vs 11%
Lack of interest	30% vs 9%

Feel there is inadequate specialist support

70% vs 44%

Conclusions

The characteristics of non-participants are the same as emerging characteristics of the Australian GP workforce.

GP participation in PC at risk of worsening

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Catch 22

The more GPs do palliative care,

the more they feel comfortable with it

(Lopez de Maturana Pall Med 1993)

Length of GP experience predicts involvement in palliative care

(Hunt Aust Family Physician 1990)

How to get GPs started in palliative care, and how to keep them there?

Possible solutions

Understand organisation of GP service delivery.

Education strategies to increase knowledge and confidence, target carefully

New service provider models to ensure GPs with family and personal commitments are not deterred from performing PC

The challenges

How to engage the uncommitted early

Develop models of integrated care for a wide range of settings

Find new ways of engaging GPs in the palliative process

Systematically identify ALL palliative patients

1. How to engage the uncommitted early

Principles for GP Skill Maintenance and Enhancement

There has to be the will to maintain or acquire the skill

There has to be opportunity to utilise the skill

There has to be support when the skill is practiced.

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Encourage the will to maintain or acquire the skill

Everyone's business

Seek PC involvement in health education at all levels

Offer GPs the opportunity to be involved at all levels

Support any GPs involvement and build up commitment.

Education and support

Financial support
Higher degree courses
Placements

Leaders

Local education
"On the case" resources
Access to consultation
Case based training
Case conferences

Participants

Established GPs

Occasional participants

Minimum skill set
Opt-in, opt-out

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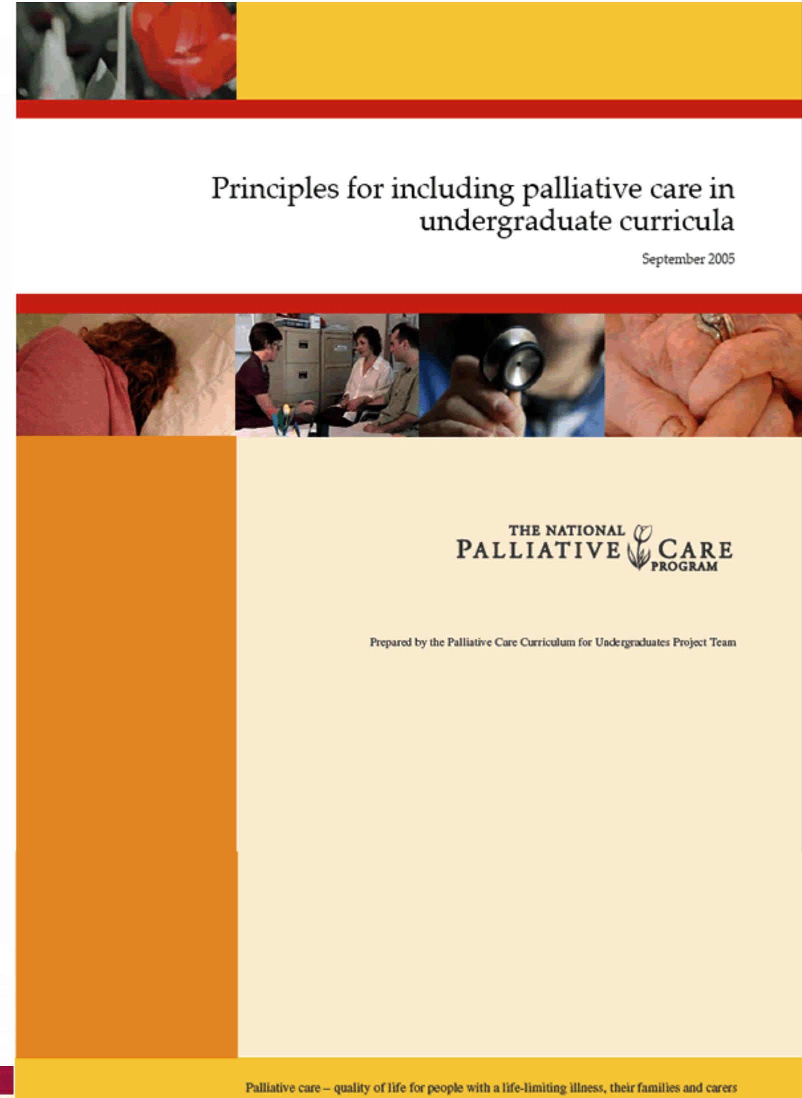
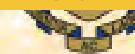
National programs

Baseline principles-

National Undergraduate Curriculum in Palliative care





Support to the committed Therapeutic Guidelines-Palliative Care

Log in to My account
Email
Password
Log in

Palliative Care version 2, 2005

Topics in Palliative Care version 2

Principles of palliative care
Emotional care of the provider of palliative care
Ethical issues
Communicating with and supporting the patient
Loss, grief and bereavement
Domiciliary care
Pertinent practical points
Getting to know your drugs
Paediatric principles and practice
Principles of symptom control
Emergencies
Intercurrent illnesses
Pain
Fatigue
Respiratory symptoms
Neurological symptoms
Psychiatric problems
Musculoskeletal symptoms
Dermatological symptoms
Haematological problems
Genitourinary symptoms
Paraneoplastic syndromes
Most common cancers
Life-limiting illnesses other than cancer
Acquired immunodeficiency syndrome (AIDS)

Endorsements
Expert Group

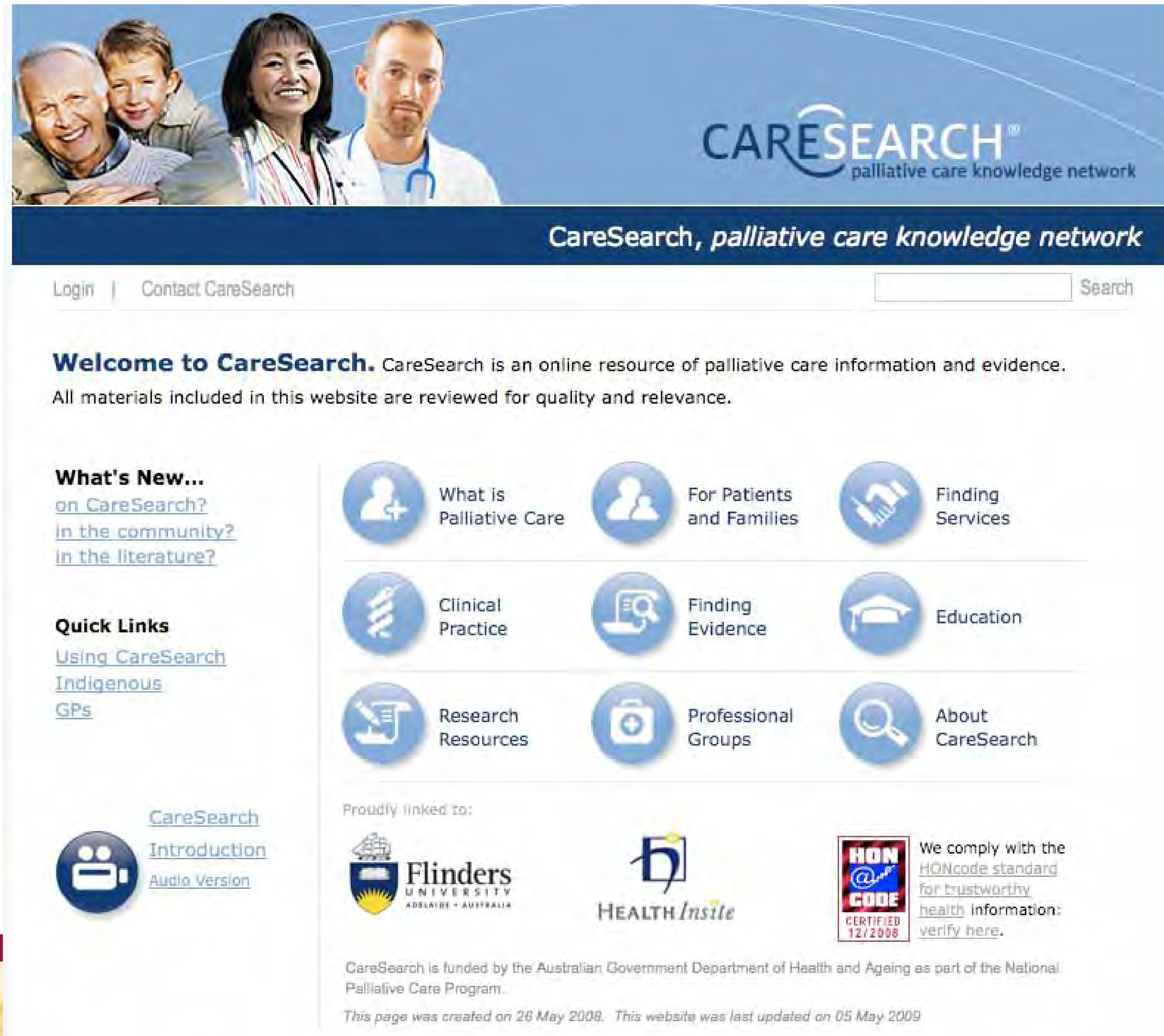
Also available in

and

www.

Caresearch (www.caresearch.com.au)

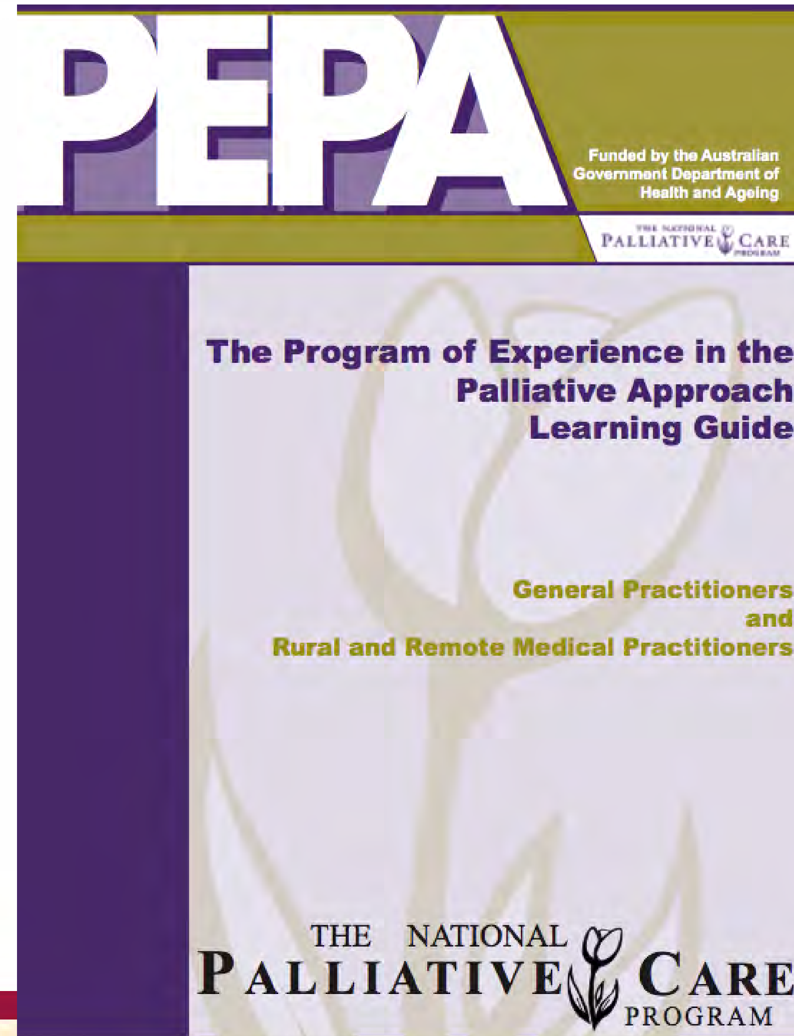
Comprehensive website that provides evidence, research tools, and professional pages for GPs (among others)



PEPA
Program of Experience in the Palliative Approach

Subsidised placements clinical attachments to a palliative care service

GPs are paid to support locum services



PCA opioid education for GPs

Primary Care & Palliative Care

On-Line Education for GPs
Opioid Medication in Palliative Care

The online education is designed to support GPs' training needs in the area of opioid medications for treatment of pain and other symptoms in palliative care patients. The packages address key issues for GPs:

- **initiating opioids**
- **changing opioids**
- **assessing pain**
- **using opioids to manage pain**
- **advantages and cautions for common opioids**
- **using opioids for dyspnoea, cough and diarrhoea**

RACGP members	ACRRM members
The online Training Package will be hosted on the *gplearning* website.	The online Training Package will be hosted on the RRMEO website.
Upon completion of the package GPs will be awarded CME points	Upon completion of the package GPs will earn PDP points.

The Training Package contains:
• Activity One: Opioid Medication & Palliation
  ○ Multi Choice Module with 25 multiple choice questions with right & wrong feedback.
• Activity Two: Tutorial on Opioid Medication & Palliation
  ○ A resource with five mini case studies focussing on palliative care patients with unique needs
	The Training package contains
	• Educational Resource summarising key issues about using opioids in palliative care
	• Training module containing:
	  ○ Five case vignettes with questions and answers
	  ○ Review multiple choice questions with feedback
	  ○ Further reading and links to relevant online sites
	A facilitator will be used to stimulate discussion about cases presented by GPs

The online Training Package will be available June 2006.	The online Training Package will be available June 2006.
To access the package: *gplearning*: www.gplearning.com.au Ph: 1800 284 732	To access the package: RRMEO (Rural & Remote Medical Education Online): www.rrmeo.com Ph: 07 3105 8200

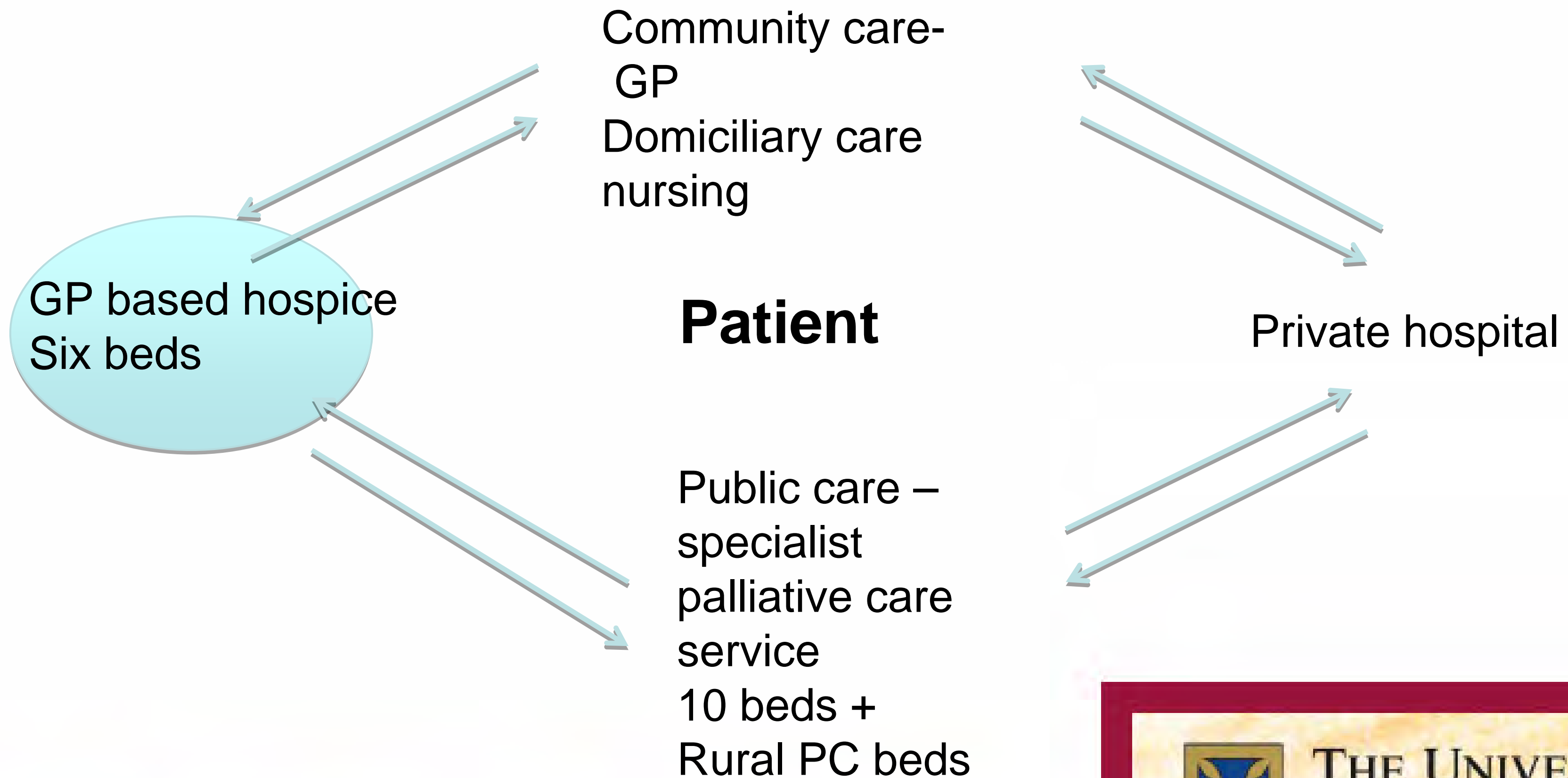
Members of RACGP and ACRRM will have free access to the training packages.
Non-members will have access on a pay by use basis.

Palliative Care Australia

2. Develop models of integrated care for a wide range of settings

Let's create opportunities….

Ipswich Palliative Care Plan - 1991



Ipswich Community Hospice

- Community owned and run
- Partial QH support
- Six beds
- GP inpatient care
- Cost not a barrier

GP care of patients as inpatients

Quality assurance initially through consensus based guidelines – “Blue Book of Palliative Care”

AND

Weekly case conferences for GPs with inpatients.

Model works on assumption that skills can be built up in whole GP population over time by steady, supervised exposure.

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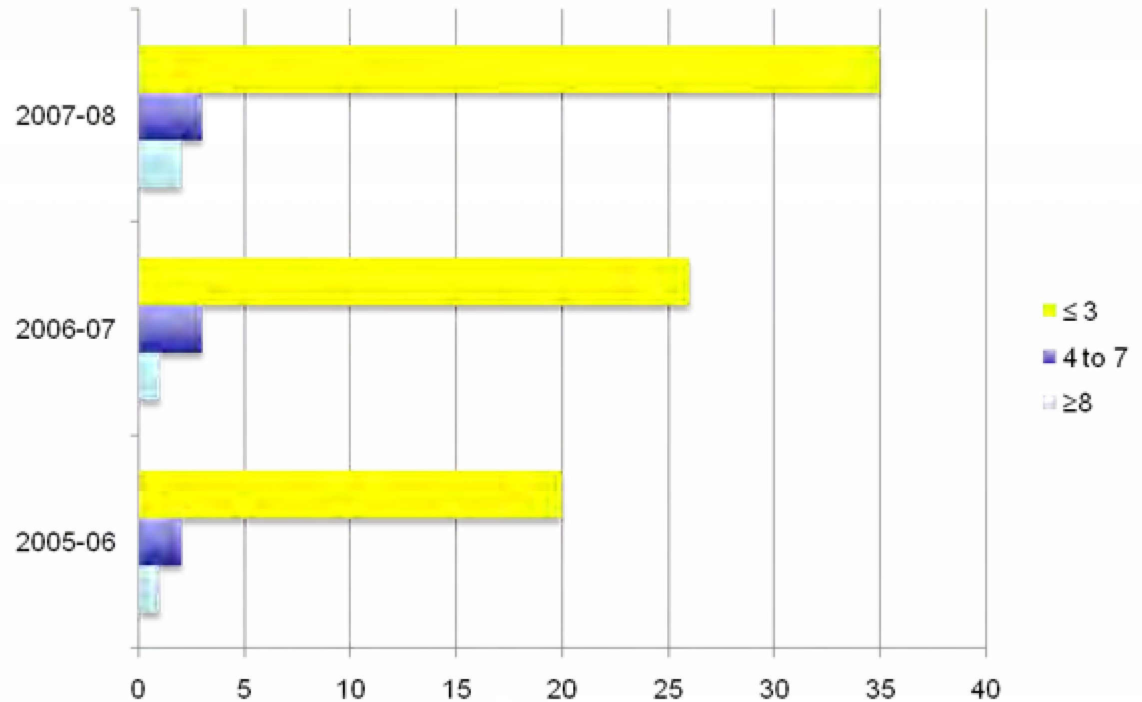
Patients since 1996. 1000th patient in 2009

GPs admitting to hospice

Year	GPs admitting to Hospice	Number of patients	Range of Pts/GP
2005-06	33	56	1-8
2006-07	30	66	1-8
2007-08	40	83	1-14

Patients per GP



One GP covers the palliative specialist at IGH and some weekends.

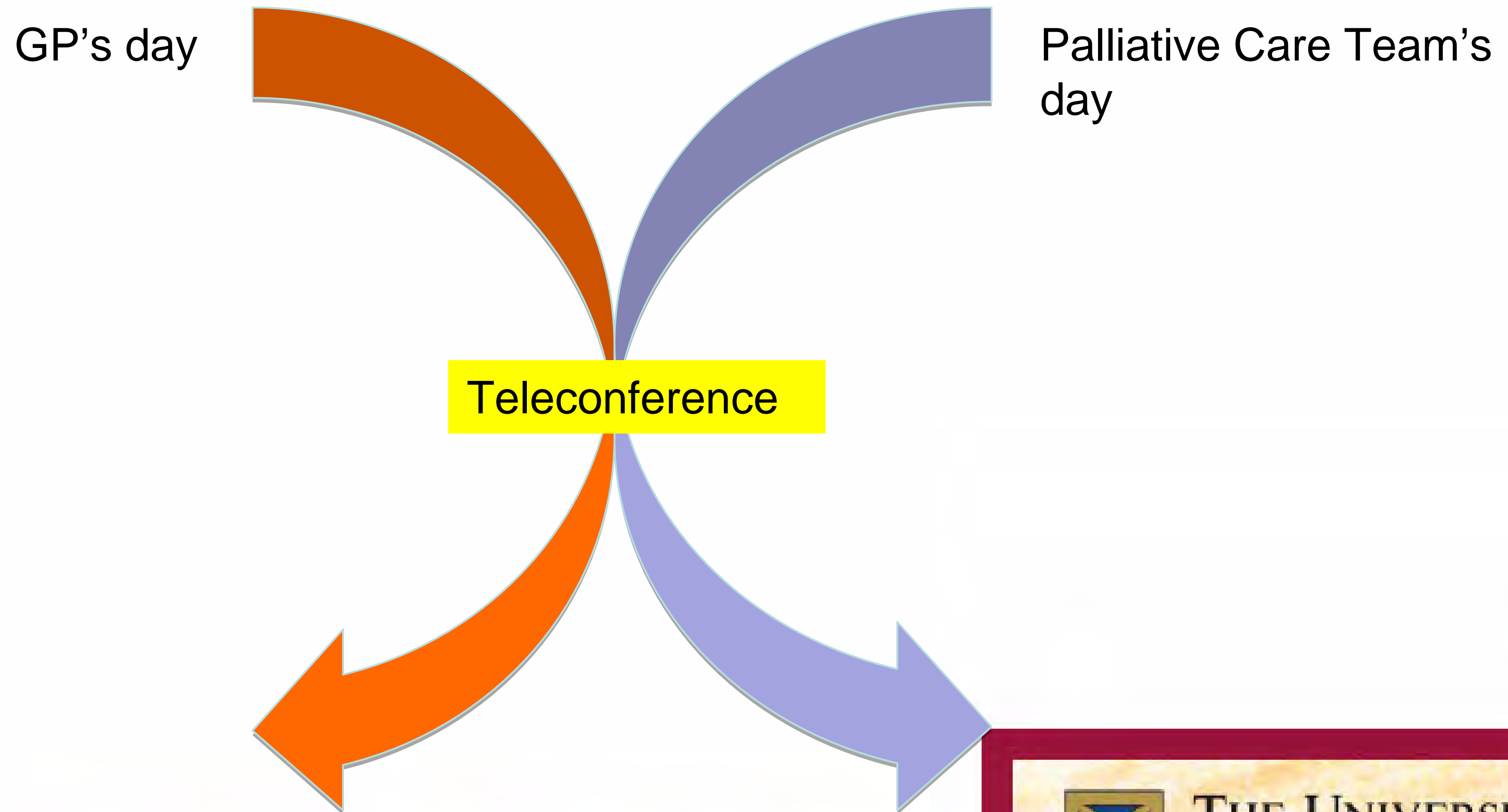
A different GP was the top user each year.

Case conferences between GPs and specialist teams

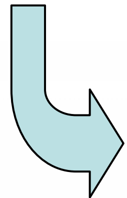
RCT of GPs and specialist teams having a case conference near the time of admission to plan care vs normal care

159 patients, three teams, 101 GPs

Teleconferenced Case conferences



Referral

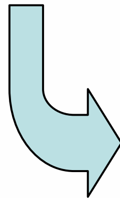


Independent of time from case conference to death

Case conference

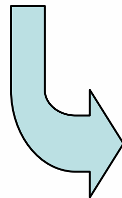
Plans established

Relationships developed



Stable phase-

Plans not needed



Illness progresses

- rapid deterioration

Plans implemented

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3. Find new ways of engaging GPs in the palliative process

1. Discharge planning – Hospital to Community

Development and testing of discharge planning which enhances GP role.

Includes patient held record and teleconferenced case conferences:

GP-specialist-home nurses

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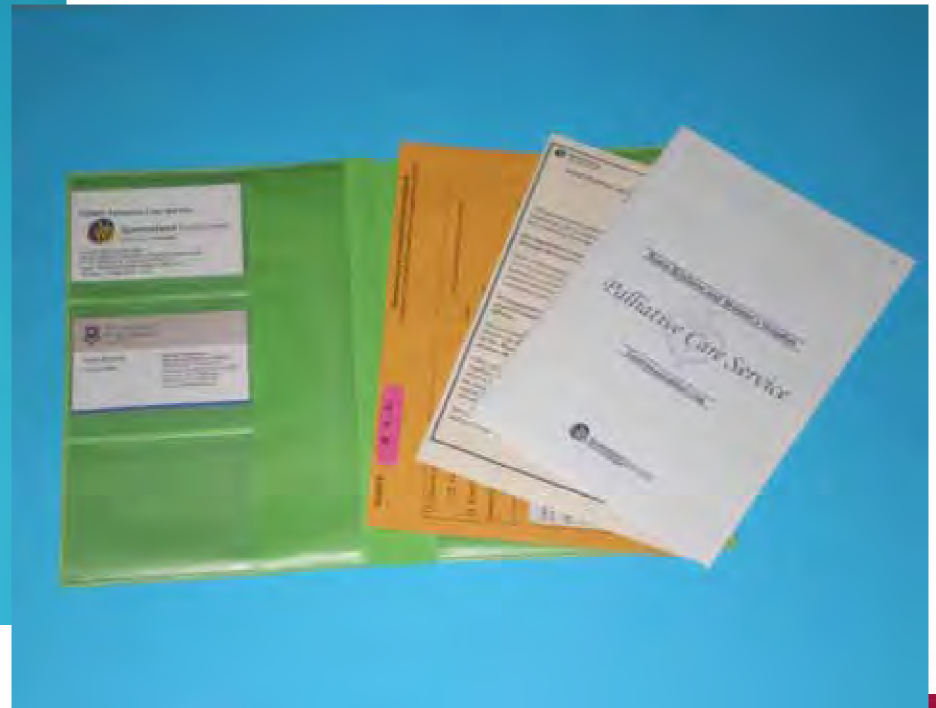
Patient-Held Record



Case conferences

A meeting between GPs and specialist services, aimed at discussing a complex case and generating care plans.

2. GP care for caregivers of palliative patients

RCT of GP care guided by a caregiver needs checklist

Carers recruited through oncology clinics

Intervention carers' GP briefed on project.

Carer needs reviewed at least twice , three months apart

Six months of followup.

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4. Systematically identify ALL palliative patients

UK Gold Standards Framework

Practice based system of delivering palliative care.

Assumes most patients have a GP, and are identifiable by asking the question

"Would you be surprised if this patient died in the next twelve months?"

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Levels of sophistication

1. Systematically identify “at risk” patients by the practice
2. Develop a plan for each patient so that deterioration does not lead to panic
3. Learn the relevant skills

Voluntary participation at first

Now part of UK contract with GPs to have a register of palliative patients

>90% uptake

The ONLY way non malignant palliative care can be systematically delivered everywhere in Australia.

A priority in Australia to develop a similar system.

Challenges AND Opportunities

How to engage the uncommitted early

Develop models of integrated care for a wide range of settings

Find new ways of engaging GPs in the palliative process

Systematically identify ALL palliative patients

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