Resource

NSW GOVERNMENT | COORDINARE | phn SOUTH EASTERN NSW An Australian Government Initiative

Southern NSW - Palliative Care Resources for GPs

Consider use of the SPICT for understanding a patient's needs and requirements for ongoing care (available on Health Pathways under criteria for referral to Palliative Care Services):

Look for any general indicators of poor or deteriorating health:

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- Progressive weight loss; remains underweight; low muscle mass.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Review current care and care planning:

- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support family carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, communicate and coordinate the care plan.

Resource

Services available to support your patient and their carers

Care Coordination Services:

Enhanced Community Care Program

(not yet available in QBN, currently running in Bega, Eurobodalla, Cooma and Goulburn)

For patients that have an existing late-stage chronic disease with limited prognosis (12-24 months) and complex health needs. Run by OTs to assist with patient health goals including maintaining their wellbeing and independence. The program provides assistance to identify and access additional health and support services to maximise their wellbeing and that of their carer.

Refer via Central Intake.

Silverchain

Offers transport support, home help, chronic care coordination, etc.

Eligibility:

- Community based
- Have a chronic medical condition and complex care needs
- Have a GP management Plan (GPMP – item 721 or 715)
- Have an Aboriginal and Torres Strait Islander Peoples Health Assessment (item 715)
- Eligible for a Team Care Arrangements (TCA – item 723)
- Aged 18 and over, or 15 and over for Aboriginal and Torres Strait Islander (ATSI)

Referral via medical software (BP/Medical Director once form downloaded from HealthPathways - search 'Care Coordination')

Phone: 1300 300 122

Social Prescribing

A 12 week program that addresses the non-clinical unmet needs that impact health and wellbeing by linking people to resources and groups for social and other support.

Eligibility criteria - people over 18 years who:

- have or are at risk of developing, a long-term health condition (including mental health), or
- are experiencing social isolation or loneliness, or
- need practical help with issues that could significantly impact on their health and wellbeing like housing issues, food security, lack of access to aged care or disability supports, domestic violence, financial stresses, low physical activity or any other significant stressors.

It is not intended for people who are experiencing an acute mental health episode.

Referral via medical software (BP/ Medical Director once form downloaded from HealthPathways - Search 'Care Coordination').

Phone: (02) 9477 8700

Virtually enhanced Community Care (VeCC)

For patients with chronic and acute respiratory diseases and mild to moderate heart failure.

Supports patient with care coordination, offers remote biometric monitoring if required and have a regular video call with a nurse or allied team member.

Refer via VeCC.

Phone: 02 6150 7032

SNSWLHD-Integratedcare@health.nsw.gov.au

Palliative Care Specialist Team

Required information:

- Advance Care Plan, if available. (Preparation of an Advance Care Plan is strongly advised for palliative care patients).
- Include any recent imaging, diagnostic information, recent pathology results.
- Include any relevant correspondence from specialists.
- Standard referral information

Refer via Central Intake

If urgent assistance is required then please call and ask for the Palliative Care Nurse:

Queanbeyan Community Health: (02) 6150 7172
Goulburn Community Health: (02) 4827 3913
Bega Community Health: (02) 6491 9800
Moruya Community Health: (02) 4474 1561
Cooma Community Health: (02) 6455 3201

Afterhours GP Support (on-call Palliative Care Specialist via Hammond Care): 1800 427 255

Other useful links for GPs:

HealthPathways ACT and Southern NSW

Easily accessible information on assessment and management of common symptoms seen in Palliative Care patients.

Username: **together**
Password: **forhealth**

Type "Symptom Control in Palliative Care"

Caresearch:
https://www.caresearch.com.au/tabid/6246/Default.aspx
This link will take you to the GP section in Caresearch.

Palliative Care Australia
https://palliativecare.org.au/

PEPA NSW
https://www.slhd.nsw.gov.au/services/pepa/

Advance Care Planning Australia
https://www.advancecareplanning.org.au/