
Palliative Care Clinical Conversation Questions

OFFICIAL

Impactful Integration of Palliative Care

Questions and Answers

Q1: I was just really interested in the advanced care planning findings and the difference between caregivers and patients. And I guess I wondered what your thoughts are and how or if it should alter our practice.

[Julie McDonald] I think this isn't the first time that we've seen such divergences between patients and caregivers regarding advanced care planning preferences. In fact, I was part of a study over in Canada by Camilla Zimmerman about early palliative care and patients with advanced cancer. And we had a qualitative paper published, which I was an author on, which found the same thing. So it does tend, as we know in clinical practice, that patients obviously diverge into groups that don't like facing the future and rather would stay in the moment, and those who don't mind looking further ahead or do a bit of planning. But yeah, it does seem to be fairly common that care givers are the ones who want to plan for the future. I think we know that already instinctively, as palliative care physicians, I'm sure there's lots of other groups that strike the mailbox chat as well. Like you go into see a patient in the community and you think you're finished your consult and you walk to the mailbox with the caregiver then says to you, now I really need to know what the prognosis is and how on earth am I going to manage and what is going to be available for me to help me manage. So I think that is universal. I do think that palliative care physicians and clinicians have got unique ability to understand that the caregiver is part of the dyad, and that the caregiver is part of that journey. And to address the caregivers needs. And I think it's pretty common in my practice to say, 'you know, sometimes the patients and the caregivers feel pretty differently on this subject', and 'do you mind if we talk separately to your family member about some practical stuff?'. But I think other physicians, well, I know some of my respiratory colleagues in particular, have said 'Oh no, the patient is my patient, I wouldn't probably go and discuss things separate to the patient'. And so, I understand that, but I think there probably is room to educate that caregivers are an important part of the care that we need to utilise. We know that very strongly in respiratory already with the caregiver being a key player in action plans and in enacting action plans, so I don't see how it's all that different.

Q2 ...Our healthcare system is set-up to be very individualistic, whereas we recognise that carer, and not only perhaps the unit of care that you're alluding, but also broader discussions with all of the care providers is really important to make sure we optimize meeting patient-centred goals, in particular. I'm wondering if someone rang you from perhaps on the other side of the Yarra and wanted to set-up a clinic such as your clinic there - a respiratory integrated clinic, what are some of the organizational barriers and facilitators that really helped you set-up this clinic and how did you overcome some of the barriers that perhaps you met when you were setting it up or even once you had it up and running?

Yeah, good question. I think there's two parts to that. The first is, well, it's time and money to set-up a clinic. There's got to be some appreciation that this style or integrated review will take longer than the usual 7 -15 minute specialist

outpatient review. These are more like 30-45 minute reviews. And although they can be done piece-meal, it's pretty difficult to do a serious-illness conversation communication without that time. I mean sometimes you can very reasonably, break it up into prognosis one meeting and then a week or two later some planning. But it has to feel held. So in regards to that [advice], It's very difficult. Depending on who is ringing me from the other side of the Yarra and to set-up practices that are really integrated or have a lot of time and palliative care and a GP practice that has to navigate the complexity of NBS billing. Which I think is currently very complex and poorly remunerated for our GP colleagues and any private specialist positions who are trying to practice palliative care. I mean that's not necessarily a barrier we can address, but there's certainly is some support out there. There's a document, that's in my reference list actually, about how to navigate the complexity of healthcare MBS codes for general practitioners in the community and also in aged care. So, I think there's that – you've got to be realistic about the time that's going to be needed to see patients [and funding for this]. Also, I think for me an important step was a business case. I think it's a really good idea if you are in a big your organisation what which might be open to a business case. There's actually quite a lot of evidence out there that is Australian-specific about the varied palliative care models and how cost effective they are, and that they are a very good return on investment. So again, in my references there's a KPMG PCA – Palliative Care Australia document called 'Investing to save: The economics of increased investment in palliative care' here, and that was just published in 2020. And it has really good data that you can encompass... And in regards to that, if you are looking to put a business case up, you really have to showcase, if you're in a hospital, those hospital level outcomes that the hospitals care about, such as reduced admissions. And what we've seen in our study has been replicated in other models of integrated palliative care. And also to look at other things that hospitals are currently very keen on. The really high levels of advanced care planning discussion we had in our program, which is again very comparable to integrated models of respiratory care and markedly higher than prevalence studies in respiratory and oncology care. So hospitals care about reduced admissions, economics, advanced care planning and advanced care regulation. And the other thing is, shown on the following slide, is that this [integrated] model of care also demonstrated that our patients cohort had a really low rate of acute hospital death. So those who died in an acute hospital in our cohort was only 30% and usually for patients with the advanced chronic lung disease, this tends to be more like 70% acute hospital mortality. So again, that reduction down to around 30% has been similarly replicated in enough integrated models palliative care research here. So those are some big barriers. And final one really, I think that if you're looking to set-up an integrated palliative care model, it has to be driven from the specialty or the primary care provider being interested to engage. I don't think necessarily just having palliative care available within the clinic is enough, as referrals won't come, or they can wane.

Q3. Does it mean, specifically, that in your clinic you need engagement with the respiratory providers or in one of the other clinics you'd need the heart cardiologists or the liver failure specialists to be able to be engaged, as well as being present yourself?

Yeah, I think so. To use the example of the integrated clinics at St Vincent's, there's liver, renal, cardiac and respiratory. Renal supportive care is run by a renal physician who has a palliative care diploma, who is a champion herself. So she can provide both disease-oriented care and the early palliative care concepts of symptom management and advanced care planning within her one review. And on top of that, she has a palliative care fellow or registrar with her. And her presence being a renal physician I think really constantly demonstrates and reinforces her value. I'm sure that's visible. I hope the same with myself being a respiratory physician. I work across many different aspects of care at St Vincent's, including outpatient care, community care, and the inpatient hospital unit. So I think you eventually do begin to have an influence on others about the importance of integrating some palliative care concepts. The cardiology supportive care clinic that we've got at St Vincent's has had a lot of referrals previously when we had a cardiac specialist who was a real champion of palliative care. But at the moment we are having a bit

more of a tricky time gaining referrals with a palliative care fellow coming across and offering care, but not really having an in-built champion within the service. So I think, that [in-built champion] can be really helpful.

Q4. What would you do, if you wanted to expand your service now?

If I had money and time, I think that things I'd love to be able to do is to have some support outside the FTE 0.1 that we have currently have within the clinic time per week. So I'd love to be able to have a respiratory educator, or similar person, who's available in business hours to educate patients, whether they are inpatients or outpatients, on disease specific action plan use, symptom management plans and be able to troubleshoot the plans and support patients to enact them. And I know that style support is available at other services. I think in respiratory and integrated respiratory service, that would ideally be a respiratory educator that could also do smoking cessation, inhaler technique, review, chest clearance and exercise education. So that would be my first desire.

The other thing I hope we're continuing to build and improve on is that you've got to have really good relationships between community and hospital for patients so that you can lever what you need to, to make sure that the patient is getting patient-centered care, so that their care isn't fractured across the hospital and community sites. So for us that's a close connection with the inpatient palliative care and inpatient units, general practitioners, pulmonary rehab, hospital in the home and the health independence program. Those would be a big key players, as well as community palliative care and psychology and psychiatry. That building and relationships is really key, so you can call on people to help. But the second part of that, which I'd love to have if possible, would be at multidisciplinary meeting, perhaps once every one or two months to discuss with those players I just mentioned any tricky or new patients.

And the other part that comes with community connections is the ability to have a home visit. Now I know for me that I've been very lucky to have access to that since 2017. But if you don't have access to that, it's really helpful to have a partner organization who you can call, such as health independence program or the community palliative care, because we certainly have had a number of patient reviews where I've been in the clinic on telephone or telehealth and that physician or the community palliative care nurse has been at home with the patient and they've been really successful reviews.

And the last thing I'd love to have, but is really pie-in-the-sky for us at the moment, is remote monitoring. It's pretty next level for us, though I know it is available in Victoria and also increasingly internationally. I'd love to have access – for patients to have apps where we could monitor symptoms, stats, peak flows and action plan use to allow the staff and technology to respond. I think with COPD in particular, if you can enact an action plan successfully, you will certainly decrease acute hospital admissions and keep people home.

[Melanie Benson] It's interesting that you mention that because in our last clinical conversation we had Tim who's the CNCC with city mission who is using an app to be doing exactly that. So the clients can use the app and do their SAS scores. From that sort of point of view, it's similar to what you're saying, and it's certainly locally available and being piloted very close by to you. So bringing those models together would be fascinating.

Q5. Thank you Julie. It's wonderful work. And apologies if you did present this, but I didn't catch the total cost for the project and therefore the savings that you presented, what sort of proportion they were to the spend. And I wondered whether just in your background reading if you had kind of predicted what you thought the cost savings might be and how it compares to other projects you've seen written up?

Thanks. No, I didn't put the absolute numbers in there, but I do have them. So, home visit cohorts' hospital costs decreased from \$531,000 to \$513,000, so a drop of \$18,000 the 90 days before and after for that 51 patients. So the total cost savings was over \$18,000. That's the exact data. So it's very difficult to tease out exactly the cost of the service because it's all sort of lumped together... but I was surprised and pleased to see that that was more or less cost neutral. Because home visits are pretty intensive. We often only get to see one patient for our FTE 0.1 of a physician per week. The outpatient cohorts' cost actually decreased from from \$477,000 to \$368,000 with cost savings of more than \$109,000, or a 23% decrease. And I think the two cohorts are quite different. So the home visit cohort were obviously a poor functioning and a poorer prognosis group. They actually had a much higher mortality rate in 90 days than the outpatient group. So it sort of makes sense to me that the outpatient group was more sensitive to the intervention than the home visit group who had more hospitalisations.

Q6. Most of your outcomes are data-driven. How much time and energy did you have to put into data collection or could you fit it into your normal practices and procedures?

Good question. So for the physicians in the clinic, which is myself and the palliative care physician, there's only two things we should really measure prospectively from the review was MMRS breathlessness score of zero to four, and the second one was AKPS performance score... So I mean both of those things, even with only the physician doing it, probably only takes about 15 seconds to pop down. I did have some research grant funding back in 2018, which helped to be sort of collect the patient details, demographics etcetera onto a database. But the hospital admissions, cumulative bed days and outpatient clinic attendances could be pulled from our hospital [database] in about 15 minutes. So that data doesn't take any time to capture. The qualitative interviews obviously took a lot more time.

Q7. What other diseases do you think this model could also work with?

My opinion of integrated palliative care is probably that it's something that every chronic disease practitioner should be incorporating a little component of it into their care.

I certainly don't think that you have to have every elderly or frail or dementia patient referred to specialist palliative care or community palliative care. There's not a need to have them referred, and there's not really capacity or options for that. But if every specialist and clinician, whether it's nurse, nurse practitioner, health independence program, clinician, or general practitioner has some ability to incorporate a little bit of palliative care within their general practice, I think that'd be excellent. But I don't mean to in any way say that this is something that can be done without time and support. Because I think, like I said, just saying 'oh, everyone should adopt integrated practice', makes it feel like everyone should adopt it in their 7-15 minute review and that's just not functionally possible to provide quality integrated palliative care.

[Melanie Benson] *I think it's fascinating. I think that it's something that probably those of us who have worked in palliative care for a while would see that it would intuitively make a lot of sense to have this integration of care. And it doesn't have to be a health care physician, it could be CNC, it could be a nurse practitioner. And being present in different environments is helpful because it comes with bidirectional learning both for health care teams but also for the other disease modalities as well. There was a clinical conversation a couple of days ago about having geriatricians in the emergency department. Again, it's been co-located to have those longer conversations. Still probably short compared to a palliative care conversation, but longer consultations parallel to the acute care that's*

happening in the emergency department. So these models will become increasingly interesting, as well as promoting person-centred care, but also capacity building within the systems in which we work as well.

[Julie McDonald] If I can add to that, in regards to our GP colleagues and what we'd love to see. If integrated palliative care was becoming more and more common throughout Victoria and Australia, what we should see is increased MBS billings and unfortunately we're seeing the opposite. We're seeing that over the last three years, there's been a slow and steady decline in MBS billings for palliative care, which is showing us something. It's showing us that our GP colleagues probably don't have support and capacity to provide palliative care in a way that they could, perhaps, even because the billing codes are too complex or just poorly, remunerated. I think if we want to see integrated palliative care becoming more standard than we need to see mechanisms of support that's not so complex and better remunerated...

[Melanie Benson] Thanks, Julie. I think we lost you right at the end there, but I think the gist is very much that this is a bit of a multi-level problem in which if we are going to have true engagement from other specialists to have serious illness conversations, and for our general practitioner colleagues it's very much necessary to have the remuneration to support the practice. And I think that's something we know is particularly relevant with the telehealth conversations that have been going on as well. I think people have been mindful of that, but it's an area that we need to continue to have innovative funding pilots to be able to support these programs.

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[Melanie Benson] In closing I'd like to thank Julie for persevering through the challenges of technology today and sharing her very valuable learnings. And I'm sure those of us who have not come to integrated clinics would love to be able to reach out to you. You're happy to take calls from across the Yarra and from other sectors about setting up your clinics and your learnings in this I'm sure?

[Julie McDonald] Of course, very happy to help.

Disclaimer: On behalf of our attendees and SCV, we would like to acknowledge and thank our speaker for taking the time to respond to questions.