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Integrating Primary Care – creating a more connected health and care system.

SOUTH AFRICAN ACADEMY OF FAMILY PHYSICIANS

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Palliative care in a rural sub-district in South Africa – a 4-year review

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Background

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- WHO: global need for good pall care, supporting people with life-limiting illnesses.
- Globally, palliative care available to 14% of individuals who need it.
- Nationally - drive to strengthen palliative care services in PHC, communities and homes.
- SA National Policy Framework and Strategy on Palliative care (NPFSPC), published 2017, in line with WHO resolution 69.17 - calls for member states to strengthen pall care systems.
- ↑ prev of non-comm diseases (Hpt, DM, Ca) and infectious diseases (HIV, TB) - need for pall care services for people dev end-stage, life limiting complications.
- Traditionally, responsibility for pall care fell to NGOs, charities & donors, outside public health systems - leading to inequitable, fragmented & limited services.
- In 2017 SA had approx. 160 palliative care services serving only 40,000 people.
- Recently - shift away from siloed approach - importance of integrating sustainable pall care into the continuum of health service delivery.
- Western Cape Department of Health prioritised palliative care
- George Sub-district became implementation site for a rural pall care model (2018).
- Pilot project evolved into a fully integrated service extending from the community home-based services and NGOs to the PHC clinics and local hospitals.

O'Brien V, Jenkins LS, Munnings M, et al. Palliative care made visible: Developing a rural model for the Western Cape Province, South Africa. Afr J Prm Health Care Fam Med. 2019;11(1), a2147. https://doi.org/10.4102/phcfm.v11i1.2147

Aim

To review the palliative care project over the last four years (2018-2022).

Objectives

- Describe the current palliative care service
- Quantify the number of patient referrals
- Describe the number of home visits
- Quantify the hospital palliative care ward rounds
- Make recommendations to strengthen the palliative care service.

Methods

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Setting

- George sub-district, Garden Route district, W/Cape Province. (pop 218 381)
- 3 NGOs employ 70 CHWs & deliver home community-based care.
- 3 community day centres, 10 fixed and 4 mobile PHC clinics
- Intermediate care facility (Bethesda) - inpatient pall care, and 1 TB hospital
- 1 regional hospital - 266-beds, with 23-bed Family Medicine ward
- Private sector offers limited formal palliative care to patients.

- retrospective descriptive
- 2018-2022

George sub-district, Garden Route district

Study Population

- All patients in the George sub-district needing pall care who accessed the government health services from Nov 2018 to Nov 2022.
- All referrals for pall care were entered into an Excel spreadsheet
- All pall care referrals were made via a standardised referral form to a secure group email address dedicated to pall care.

Sampling

- Data initially collected for clinical rather than research purposes, ~ pragmatic approach to data collection used; additional variables added as service grew.
- Variables included patient demographics, diagnosis acc to the validated Supportive and Palliative Care Indicators Tool (SPICT) classification, number and origin of referrals made, number of home visits made and by which healthcare professionals, and the date and place of death.
- Data from pall care hosp w/rounds were collected via the EpiCollect5© app.

Results

1. Palliative care model
2. Training
3. Referrals
4. Home visits
5. MDT ward rounds

1. Palliative Care Model

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- 1-page referral document - emailed to palliative care group address.
- Multi-disciplinary teams: reg. hosp, intermed facility, subdistrict & community
- Weekly MDT ward rounds at above facilities – referred patients reviewed.
- Close collaboration between DOH and NGOs – comms via Whatsapp groups
- 3-4 X/week ward rounds at intermediate care facility by sess. pall care doctor, +/- med student or junior dr.
- 2-monthly strategic planning & review meetings with pall care stakeholders at regional hospital, governed by the Department of Family Medicine.
- Home visits daily - first visit by sess. pall care doctor and/or PHC nurse from NGOs - subsequent visits made based on patient needs. Undertaken at varying frequency & by diff MDT members depending patient needs.
- Telephonic follow-ups.

Simple tools ~ effectiveness & feasibility.

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1. SPICT tool to encourage the identification of suitable patients.
2. 1-page pall care plan served as a referral letter, for follow-up in the community
3. Central prov group email address served to facilitate efficient referral pathways and follow-up.
4. EpiCollect5© to capture ward rounds data
5. Microsoft OneDrive file ensured data availability that was regularly reviewed and acted upon to identify and address systems issues.

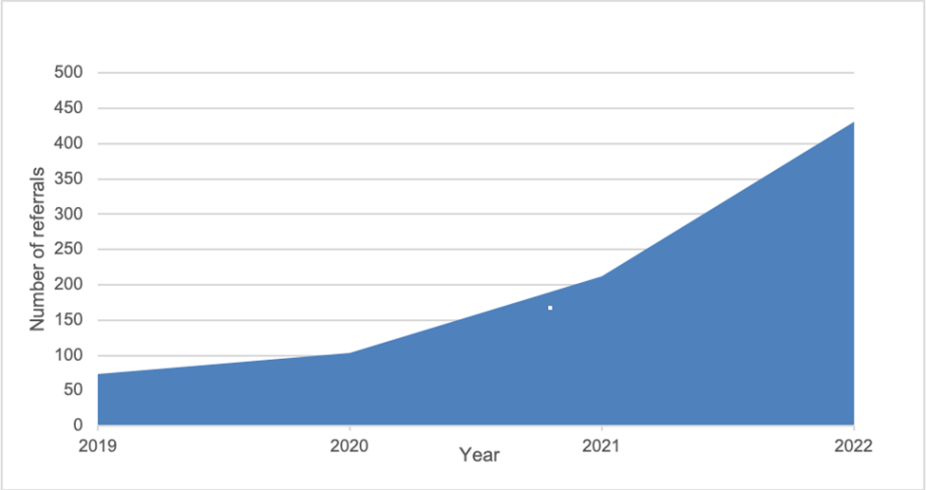
2. Awareness and Training

- District wide awareness of palliative care actively maintained.
- MDT format of training NB.
- CME sessions, bedside, formal undergraduate & postgrad student teaching.
- Accredited training - 5-day short courses (face-to-face) & 10-week online formats.
- Sessional pall care doctor trained all CHWs in palliative care.
- Twice daily handover ‘huddle’ at the reg hosp EC: all patients with PC needs in the unit or admitted to the FM ward are discussed & assigned ICD-10 PC code.

3. Referrals

- 819 patients referred
- 2019: 64 patients were referred
- 2020: 124 patients were referred
- 2021: 214 were referred
- by 30 Nov 2022: 431 for the year.
- made for patients living in 17 residential areas.
- Greatest number - patients living in Thembalethu (161 referrals)
- 87% from the regional hospital
- 6% by the PHC clinics.
- Average age of adult patients 61 years.
- 12 children were also referred to the pall care team.

~ average referral increase of 89%/year



Diagnoses acc to SPICT criteria

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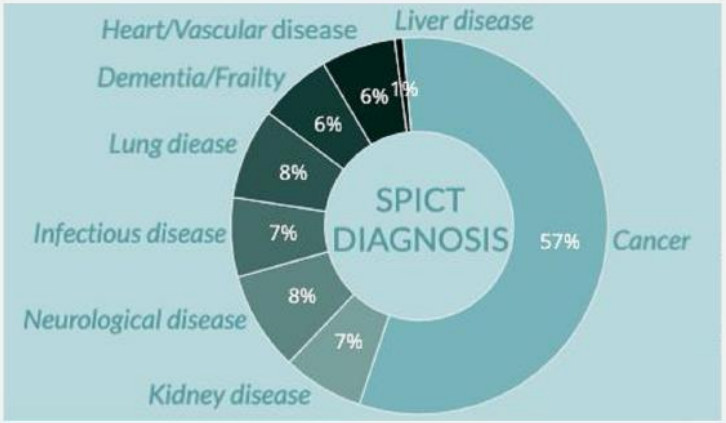
- cancer (57%)
- kidney (8%)
- neuro (CVAs) (8%)
- lung (8%)
- infectious (7%)
- frailty/dementia (6%)
- heart/vascular (6%)
- liver (1%)
- Trauma/haem (0%)



4. Home visits

- Initially not part of routine data
- Manual data analysis:
  - at least **152 home visits recorded**
- Underestimation: many carried out informally prior to obligatory capture.
- Post study: home visits have become part of routine data collection.
- E.g. Nov 2022, 38 home visits were carried out: 17 were attended by a nurse, 10 by a social worker, 8 by a doctor and 8 by a CHW.

Activities during home visits

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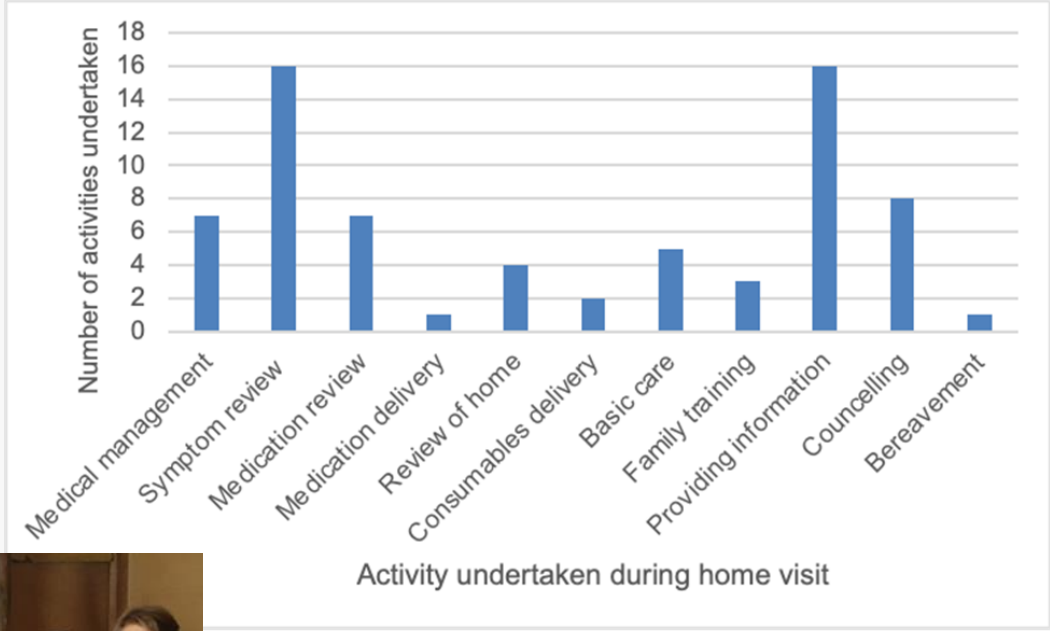
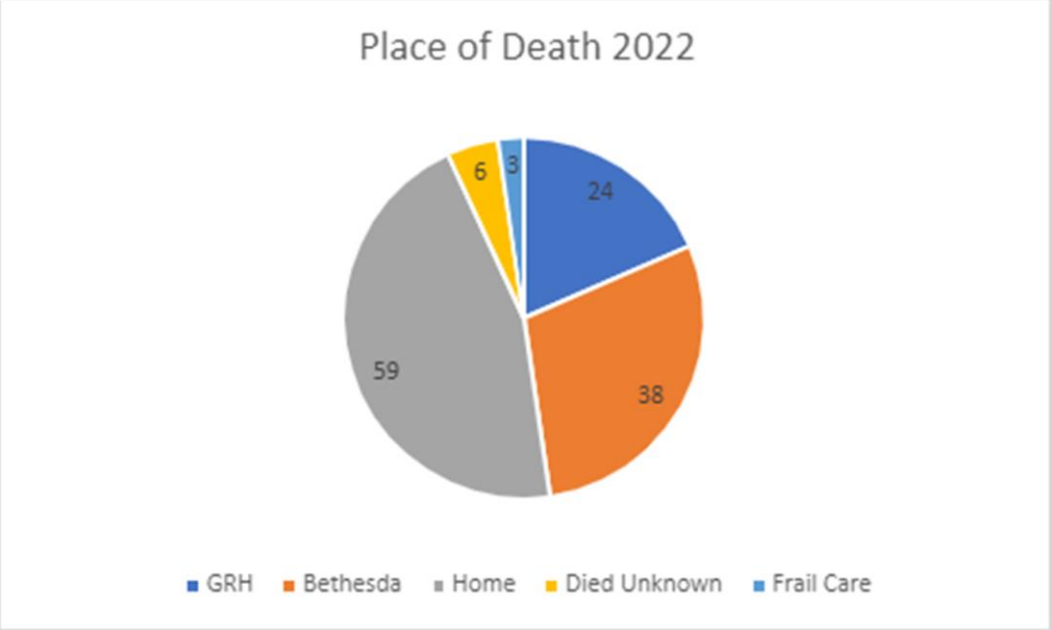
1. Reviewing symptoms
2. Providing information: (2 most common)
3. Other:
   - prescription, adjustment and delivery of pall meds and consumables,
   - basic care provision and family training,
   - counselling for the patient and the family.



Place of death

- 46% died at home
- Increasing as home-based pall care has increased in the community.
- E.g. Nov 2022, 79% of patients died at home, in accordance with their choice.



5. MDT ward rounds

- 122 MDT hospital rounds.
- 345 patients reviewed.
- Av 75 minutes spent per w/round.
- 95% attended by pall care spec dr.
- 91% by social worker
- 82% by physiotherapist
- 30% by psychologist
- 79% by doctor & 30% by ward nurse from patient's ward team
- Emphasised MDT ownership of care by the ward team.

Conclusion

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- Model evolved from pilot project (2018) to established, integrated service component of subdistrict health system (2022).
- Key factor for success and sustainability: champions continuously advocating for improved pall care services.
- Team of doctors in hosp and PHC, PHC nurses, CHWs (NGOs), allied healthcare colleagues including physios, social workers and psychologists, and managers created a network of PC providers ~ allowed the project to become embedded in the health services
- Focus on **shared patient care,** reducing specialty silos, aim of every health carer feeling confident to manage patients with pall care needs.

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