"TRANSDISCIPLINARY ALLIED HEALTH: MORE THAN THE SUM OF ITS PARTS"

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KEYWORDS

Supportive Care

Transdisciplinary Allied Health Care

Collaborative approach

EXECUTIVE SUMMARY (100 words maximum)

Transdisciplinary models are a unique way of working and evidence suggests that early identification of symptoms and management can help reduce hospital presentations and reduce the risk of complex grief. This new district wide, allied health service, "Supportive Care for Chronic disease", aims to reduce overlap between professions, increase coordination and collaboration with carers, service providers and GP's, enabling the patient & carer to feel empowered to take control of their last 2yrs of life.

INTRODUCTION

Problem: The role of allied health in palliative care is recognised, but still emerging. With little consensus on member professions, it is difficult to capture the group potential of these services in palliative care. A recent study of Australian allied health clinicians showed they play an active role in physical, social, and psycho-spiritual care of palliative care patients and carers. The participants noted that given increasing numbers of palliative care patients in non-specialist settings, this care within a palliative care context is likely to be an increasing responsibility. Supportive Care models can help bridge the gap between Chronic Disease and Palliative Care in the last 2 years of life. Access to allied health services can help to maintain a person's function, wellbeing, and quality of life for longer, with less need for costly admissions and interventions from the health system.

HIGHLIGHTS

1. There is increasing demand on Palliative Care services and Chronic disease has a significant impact on hospital presentations.
2. The value of Allied health in palliative care is recognised, but still emerging.
3. Supportive care and transdisciplinary models with an allied health team can help bridge the gap between Chronic Disease and Palliative Care in the last 2yrs of life.
4. Overall reduction in hospital presentations.
5. Overall, a service where patients and carers feel heard, supported and improve system navigation.

METHODOLOGY/ PROCESS

Tasks:

Previous Hunter New England research with patients with Advanced Liver Disease showed the benefit of Supportive Care interventions and hence now expanded to other chronic disease groups. The model is built on relationships with key referrers, involving them in each consultation, increasing capacity around Advance care planning. The Allied Health Team's diverse range of skills and backgrounds empowers patients and links them with services in their own communities, leading to a flow on effect of reduced reliance on hospital systems. After each Transdisciplinary appointment, a summary letter is sent to the GP and referrer to keep all parties included. By

addressing functional limitations, Supportive Care models can help people stay at home for as long as possible and ultimately, continue living whilst dying.

Action:

Our 12-week Supportive Care for Chronic Disease program involves 4 allied health monthly sessions and midway, we provide 1 separate carer contact. The Allied Health team includes Dietitian, OT, Social Work and Speech Pathology, with the option for Psychiatry input where required. Prior to each appointment, our Allied Health Assistant uses a range of Patient Reported Measures (or PRMS) which forms a patient/carer led model, leading to positive engagement and better outcomes. The team provides symptom management education, resources, referral pathways and general support. Involving referrers or other treating parties in appointments and feeding back to GP's ensures all parties in care are collaborated with. Overall, Transdisciplinary work is "*an approach to creating and carrying out a shared social contract that ensures multiple health disciplines, working in concert, are worthy of the trust of patients and the public in order to improve the health of patients and their communities."*

RESULTS/ OUTCOMES

Patient's emergency department presentations and admission data has been recently reviewed and compared to 6 months prior to SCCD involvement, whilst on service, and 6 months post SCCD Program and the 18 patients that completed the "12 week" program show a reduction in hospital admissions and bed days. In review of the data of our program over a 6-month period, we have had a 40% reduction in ED presentations, a 75% reduction in admissions and we have saved 135 bed days.

Of all the patients seen with the 6-month data so far, 59% have been through Telehealth (My Virtual Care), 36% are over the phone and 7% are face to face, depending on the patients preference and proximity to our clinics. Our patients and carers report feeling listened to and supported by health professionals and that their health journey is easier to navigate after being part of the 12-week program.

CONCLUSION

Lessons learnt from this service;

Distance is no barrier, despite common beliefs, people in their 90's can independently (or with assistance) access telehealth. Telehealth can continue to achieve great outcomes, saving travel time and empowering patients and carers to manage care in the comfort of their own home and community. Education around symptoms is a gap that is filled and saves on GP/emergency presentations, enabling a person & their carer to be more educated and prepared in their journey to dying.