BRIDGING THE CARE GAP BETWEEN HOSPITAL DISCHARGE AND COMMUNITY PALLIATIVE CARE – THE RAPID PALLIATIVE CARE INREACH DIVISION (RAPID)

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INTRODUCTION

Globally there is increasing demand for specialist palliative care. Most people's preferred place for end-of-life is at home, and, community palliative care (CPC) services are in high demand. In Australia, for patients with palliative care needs, there is often a delay between hospital discharge and when CPC has capacity to accept a new patient. To assist with this gap, our unit, based at a major tertiary health network, implemented a novel service– the Rapid Palliative Care In-reach Division (RAPID).

RAPID was implemented in January 2020. Due to COVID-19 restrictions, the service predominately delivered care via telehealth, in collaboration with other hospital outreach services. RAPID provides a business hours bi-disciplinary service with clinical nurse consultants and palliative medicine specialists.

OBJECTIVE

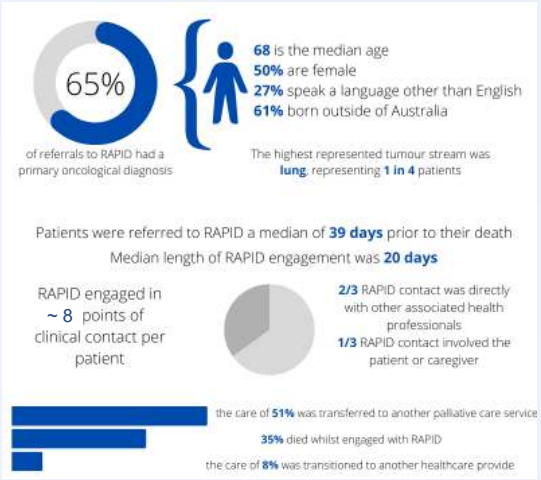
To describe the oncological cohort, clinical activity and outcomes of this novel RAPID model of in-reach palliative care.

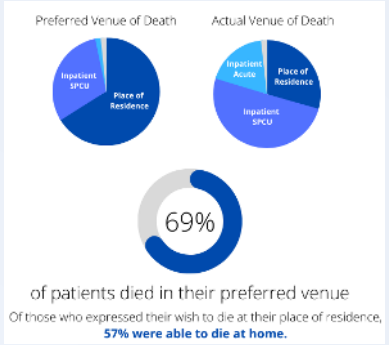
METHOD

Demographic and clinical activity data was prospectively collected. Multidisciplinary intra-team case reviews were undertaken to ascertain the scope of impact of this novel service on a sample of patients.

RESULTS

During the period of January 2020 through September 2022, a total of 622 patients were referred to the RAPID service. Of these, 404 (64.95%) has a primary oncological diagnosis. Referrals typically came from within the health service, either from the Palliative Care Consult Service (40.45%) or the Hospital in the Home program (36.23%).





RESULTS CONTINUED

Upon multidisciplinary case review, RAPID felt that they were able to positively impact a patient's care trajectory in **75% of referrals**.

Most significant area of RAPID involvement:	
Symptom Management	28.33%
Care Coordination	26.67%
Gap Fill	19.44%
Support for Other Services	13.89%
Carer Support	10.00%

CONCLUSION

Our data demonstrates that appropriately integrated models of supportive care that provide short-term specialist palliative care input, such as RAPID, can effectively provide telehealth bridging support for oncology patients by;

- Improved symptom management,
- Care co-ordination,
- Allowing care delivery in line with individual preferences, and
- Providing gap fill until community palliative care services are engaged.

Future research into the RAPID model should look towards the integration of patient reported outcome measures and further clinical capability within the home.

Using predominately telehealth, our RAPID model successfully addresses palliative care needs for patients between hospital discharge and CPC in a population vulnerable to unplanned emergency and hospital admissions.

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