

Palliative Pathway Activation (PPA)

Poi is an initiative by Auckland's Specialist Hospices to help general practice and residential care providers deliver the best possible quality of life for patients and their family/whānau during a person's final 6–12 months.

General practice and residential care joining Poi will build skills and confidence in palliative care. Poi enables:

- Consistent earlier identification of people with palliative needs
- Payments for the development of a simple palliative plan with patient and whānau
- Discussion with the Poi Clinical teams
- Improved linkages to community support for patients and whānau
- Opportunities to access coaching and support packages to build palliative care skills.

A palliative plan is the first step to improve palliative care and outcomes.

1. Patient identification and preparation

Clinicians should use their judgement and knowledge of the patient with support from tools such as the Supportive & Palliative Care Indicators Tool (SPICT) to determine when a person is best cared for as a palliative patient. Go to www.poiackland.co.nz to access the SPICT tool and Poi palliative care plan.

- Where possible, clinicians should develop a plan with a palliative patient at least six—twelve months prior to the expected time of death.
- Offer and arrange a meeting with the patient and others they may wish to invite. While you know your patients best, we suggest indicating that the meeting is to explore further where they are in their illness and plan towards the future.

2. Palliative care family/whānau meeting

A meeting should be scheduled with the patient and family members. The meeting will be guided by the Poi Palliative Care Plan template and covers a holistic view of palliative care including:

- Clinical condition
- Social and cultural needs
- Emotional and spiritual needs.

Patient consent is requested to allow sharing of the plan with the Poi Clinical team. A \$150 payment is made to the provider on completion of the plan. The plan can be printed and given to patients and can be imported into patient clinical notes.

3. Discussion with the Poi Clinical team

Following completion of the palliative care plan, general practice and residential care will receive discussion on management of their patient from the Poi Clinical team. This advice will be based on each patient's needs and may cover medical and psychosocial issues or guidance on service coordination. The specialist advice will:

- Identify local services and referrals that may support the patient and whānau
- Facilitate clinical skills development in palliative care
- Support clinical decisions
- Increase efficiency if a specialist referral is required.

Payment and specialist advice

Clinicians access the Poi Palliative Care Plan through the regional POAC service or through your PMS system—visit www.poiackland.co.nz

POAC will administer your \$150 (+ GST) payment for completing a Palliative Care Plan, and transfer information to your local hospice Poi team.

The hospice Poi team will review the Palliative Care Plan and provide advice

plan

\$150
payment

advice

For more information on Poi:

- Visit the Poi webpage on the POAC infrastructure at poiackland.co.nz
- Contact your local hospice MDT

Tōtara: Poiadmin@hospice.co.nz

Franklin: Poiadmin@franklinhospice.org.nz

Mercy: Poiadmin@mh.org.nz

Hospice West: Poiadmin@hwa.org.nz

Harbour Hospice (North Shore, Hibiscus, Warkworth & Wellsford):

Poiadmin@harbourhospice.org.nz