GP Consultation – End of Life and Palliative Care in Residential Aged Care

PRE READING PACK

Government of Western Australia
Department of Health

WA Primary Health Alliance
Better health, together

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An Australian Government Initiative

Pre Reading 1

HealthPathway Review

Entering a Residential Aged Care Facility

Pre Reading 1: Overview of previous consultation

HealthPathways purpose

- HealthPathways offers clinicians locally agreed information to make the right decisions, together with patients, at the point of care.
- Each pathway provides clear and concise guidance for assessing and managing a patient with a particular symptom or condition.
- Pathways also include information about making requests to services in the local health system.
- Content is developed collaboratively by general practitioners, hospital clinicians, and a wide range of other health professionals.

HealthPathways Pre-Reading

Please review the Before Entering a Residential Aged Care Facility found here https://wa.communityhealthpathways.org/52383.htm

Please use the following credentials to log into HealthPathways

Username: connected
Password: healthcare

**Please note, access to HealthPathways WA is for health professionals only and log in details are not to be shared with the general public.*

Pre Reading 2

JULY 2021 COLLABORATIVE FORUM OVERVIEW

End of Life and Palliative Care in Residential Aged Care

COLLABORATIVE FORUM: End of Life and Palliative Care in Residential Aged Care

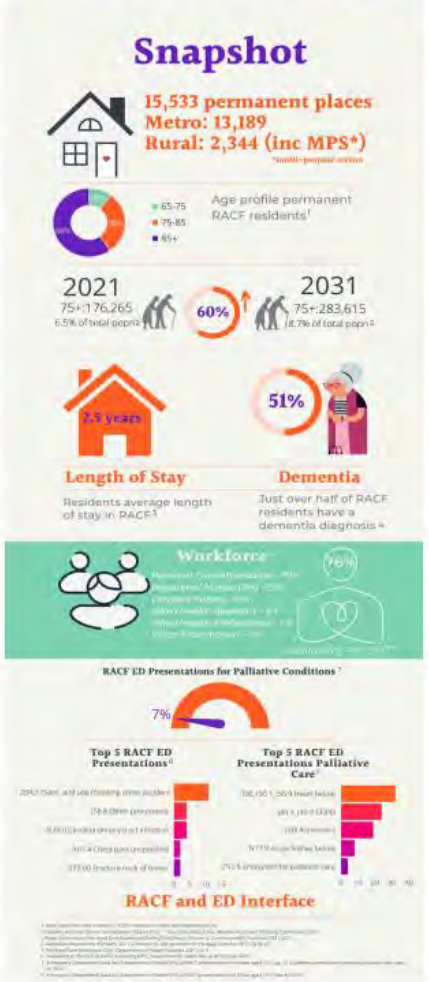
FORUM SUPPORT OVERVIEW

Government of Western Australia
Department of Health
End of Life Care Program

What is the National Partnership Agreement (NPA)?

- The Commonwealth initiated National Partnership Agreement (NPA) aims to improve End of Life and Palliative Care (EOL&PC) for Residential Aged Care (RAC) residents and their families/carers by expanding existing models of care or supporting new approaches to the way care is delivered or commissioned for older Australians living in RAC. $11.4M over four years (until 30 June 2024) has been offered by the State and Commonwealth Governments for projects that aim to strengthen national efforts to improve access to quality palliative care as a key component of an integrated health and aged care system.

Snapshot – selection of relevant statistics and data



Palliative Care – Strategic Landscape (National, WA and Local)

NPA – What's been done so far in WA?

- Extensive planning and consultation for the 4-year NPA Project has been undertaken by the End of Life and Care Program (EOLCP) to better understand the palliative care in aged care sector and the opportunities and challenges. Activities have included:

Strategic planning based on integration of learnings from literature, including:

- *My Life, My Choice Report of the Joint Select Committee on End of Life Choices 2018*
- *Royal Commission into Aged Care Quality and Safety – Final Report: Care, Dignity and Respect 2021*
- The Independent Review: Consumer perspectives of palliative care service models
- *WA Sustainable Health Review 2019* – Strategy 3: Great beginnings and a dignified end of life (Recommendation 9: Achieve respectful and appropriate end-of-life care and choices)
- *WA End-of-Life and Palliative Care Strategy Implementation Plan One 2020 – 2022 (IP1)*

Consultation exploring challenges and opportunities at events in February and September 2020:

- Representation included Leading Age Services Australia (LASA) and Aged and Community Services Australia (ACSA) members. Targeted consultations with key stakeholders will be continued over the life of the NPA project.

Funding of two NPA WA initiatives as part of the initial Agreement. These included:

- Metropolitan Palliative Care Consultancy Services (MPaCCS) – expanding the specialist in-reach model to build capacity and capability using patient-based care episode and scenario training. The expanded model aims to increase RAC residents' access to quality specialist EOL&PC in the outer east metropolitan region, and through the hospital liaison nurse, supporting integrated EOL&PC across hospitals and RACFs.
- Palliative and Supportive Care Education (PaSCE) – the Residential Aged Care Excellence in Palliative Care (RACEPC) project provides targeted education, training and mentorship to develop RAC workforce capability and capacity to provide quality EOL&PC services to residents and families. The training program will be delivered in consultation and collaboration with RACFs.

Outcomes

- The quality of life (physical, psychosocial and spiritual) of older Australians with a life-limiting illness living in RACFs, and their families/ carers, is improved.
- RACF residents and their families/ carers receive quality of EOL&PC that meets their changing needs and known wishes.
- The EOL&PC experience of families and carers of RACF residents is improved.
- RACF residents experience a "good death" in their place of choice, in accordance with their known wishes.
- The capacity, capability and confidence of the clinical and non-clinical RACF, primary care and hospital workforce to provide quality EOL&PC is optimised.
- The community's confidence in the quality of EOL&PC provided to RACF residents and their families/ carers is increased.
- Health system resources are used more sustainably, including reduced demand on specialist EOL&PC.

Impacts

Health and Quality of Life

- Reduced resident system burden and inappropriate/unnecessary procedures, hospital referrals, admissions and length of stay (LOS).
- A better experience of death and dying for residents and families/carers.
- Increased resident, family/carer and staff satisfaction.

Access and Choice

- Increased access to quality care options informed by regular assessments, Advance Care Planning (ACP) and Goals of Patient Care (GOPC) planning.
- A higher proportion of RACF residents die in their place of choice.

Understanding

- Improved resident and family/carer understanding of EOL&PC, inform planning and decision making.

Capability and Capacity

- A higher proportion of RACF, primary care and hospital staff have the necessary knowledge, skills and confidence to provide quality EOL&PC, within their scope of practice.

Care Coordination and Communication

- Improved coordination and communication among and between RACF, primary care and hospital staff and improved integration of the health and aged care systems.

System

- Reduced inappropriate/unnecessary procedures/treatments, hospital referrals, transfers and admissions.
- More timely involvement of specialist EOL&PC services.
- Improved RACF workforce staffing levels and retention.
- Enhanced community confidence in the EOL&PC provided to RACF residents and their families.

NPA Palliative Care Residential Aged Care Forum Objectives - 21st July 2021

- To bring together RAC and EOL&PC sector stakeholders to consider how to best support WA RAC providers to meet the EOL&PC needs of residents and their families.
- Information sharing and opportunity to discuss and prioritise EOL&PC service delivery models, ACP, and education and training provision.
- Best inform the expenditure of the remaining NPA funds for such initiatives, based on consideration of implementation barriers, enablers and opportunities.
- To provide an opportunity for participants across the network and continue to build relationships.

StepBeyond

Challenges and gaps identified through 2020 stakeholder feedback and consultation

Access to palliative care services:
- Inadequate access to and interface with specialist care, for example:
  - No out-of-hours, 24/7 specialist in-reach palliative care consultancy service (i.e. Bethesda Health Care's Metropolitan Palliative Care Consultancy Service [MPaCCS] operates 0900-1700 weekdays).
  - Smaller sites that do not have 24/7 nursing staff must rely on Silver Chain after-hours services. This can result in a disjointed approach to care for the patient, family and carers; and lead to inconsistent support for staff where after-hours nurses are new to a patient's case and unaware of established approaches and care.
- Inconsistencies in resource access across RACFs (i.e. Niki pumps in regions).

Advance care planning:
- Advance care planning discussions often occur too late in the journey.

Service delivery:
- Misperception that palliative care often focuses on the very end-stage of a person's life.
- A broader approach than just "bedside-only support" is needed to meet the changing needs of residents in RACFs.
- Duplication of resources and interventions.
- Inconsistent provision of palliative care across GPs (and locums) – some GPs do not feel supported without on-site nurses/staff trained in palliative care and expressed concerns with the lack of engagement with DoH (e.g. around Personal Protective Equipment).
- More needs to be done to enhance working relationships between nursing staff and GPs based on an understanding of each practitioner's discipline and expected roles in RACFs.
- Inadequate support for GPs to deliver palliative care.

System integration and coordination:
- RACFs are expected to navigate a complex care system to access palliative care support for residents.
- Inadequate transitions and pathways involving communication, engagement and care coordination between primary, acute and RACF settings:
  - Hospital transfers are often unnecessary;
  - Inconsistent assessment/ referral models – e.g. there's no well-defined process for palliative care.

Education and training:
- Translating training into practice.
- Inadequate assessment and evaluation of education and training needs and outcomes.
- Inadequate staff coverage/back-filling to enable education and training.
- Lack of family and carer understanding of the contemporary palliative care approach leads to difficulties providing care.
- RACFs will need to be upskilled to provide quality EOL&PC without needing specialist support – especially as EOL&PC demand is anticipated to increase over the next 30 years due to an ageing population and reliance on specialist services.

Funding:
- Failing to acknowledge or fund the time taken to provide and coordinate social, emotional and spiritual support.
- Need for discussion about what can and cannot be claimed for palliative care for patients and residents under Medicare.
- Aged Care Funding Instrument (ACFI) is not fit-for-purpose. Many RACFs do not even access this end of life specific funding and in some cases, access results in a funding decrease.
- ACFI is not paid until the last day of life which is the most intense day of end of life care staffing.
- Medicare items and payments for Nurse Practitioners are very limited and are not comparable to those of GPs.

Data, information management and measurement:
- Need for standardised data collection for palliative care service provision in aged care.
- Need to improve data capture in Emergency Department and patient administration systems.

Opportunities and improvements suggested through stakeholder feedback and consultation

Access to palliative care services:
- Provision of 24/7 RACF support to assist with deteriorating residents. This could be via an on-call service and/or Telehealth service.
- Expand Residential Care Line (RCL) to regions.
- Provide an all-week Nurse Practitioner consultancy service to collaborate with GPs and RACF staff.
- Ensure centralised access to resources – and map RACF variations to find solutions e.g. unequal equipment access.

Service delivery:
- Develop a Centre of Excellence based on successful RAC EOL&PC case studies.
- Develop contemporary models of care for EOL&PC in RACFs so patients are not passed between service providers or bounced between facilities and hospitals – e.g. real local success stories, evidence-based ELDAC model for the basis of in-reach services.
- High acuity, dementia model could be a useful parallel for palliative care.
- Increase support for RACFs to put in place more permanent solutions that will enable excellent palliative care services independent of consultancy services.

System integration and coordination:
- Build on exemplars of RACFs with established communication/referral pathways.
- Support RACFs to create in-house palliative care teams that feed into groups representing all sectors to ensure best practice and access to resources.
- Work collaboratively to provide link team services.
- Develop robust local pathways and solutions that include access to local skill, particularly in the country.
- Determine key trigger points for palliative care and hospital attendance (applied locally). This may involve root cause analysis of reasons for hospital transfers.
- Establish a clear governance structure for GP engagement that includes more support and education to meet the care and prescription [including Schedule 8 drugs] needs of residents.
- Increase the effectiveness of engagement and relationships across the system including GPs, WAPHA and other GP groups in the delivery of EOL&PC, especially in rural areas.

Advance care planning:
- Increase engagement with Australian Health Practitioner Regulation Agency (AHPRA).
- Establish End of Life Direction for Aged Care.
- Ensure centralised access to ACP resources.
- Engage with NGOs and community groups to increase access to support completion of ACPs and AHDs.

Education and training:
- Increase RACF staff education about the palliative care system, available services and need for early resident engagement.
- Provide ongoing contemporary education and training tailored to RACF staff levels, roles and professions, so staff can support each other up and down respective workforce structures.
- Integrate voluntary assisted dying (VAD) education with EOL&PC education with supporting policies and processes.
- Provide training modules on: the 'deteriorating patient', ACP and communicating contemporary palliative care approaches to families and carers.
- Provide education for hospitals to better understand and reduce confusion regarding RAC and palliative care.
- Implement a multi-pronged approach to GP training involving WAPHA, RACGPs and individual GPs.
- Standardise and mandate contemporary palliative care training for GPs as a condition of employment.
- Additional training and support on referral pathways to primary care and specialist palliative care.
- Develop education and training that fosters collaborative relationships between GPs and nurses.
- Measure the impact of education and training.

Funding:
- Funding dedicated ACP and GOPC roles to promote early discussion with residents (including when an older person is considering entering an RACF), as in other countries.
- Access to funding to backfill staff attending EOL&PC education and training e.g. ELDAC and South Australia provide grants to support staff.
- Change the definition of Medicare rebate numbers for GP provision of palliative care in RACFs to more accurately reflect actual time spent.
- A funding model based on NDIS to improve equity.
- Develop a state-based project that addresses the Royal Commission findings (e.g. funding for high-level nursing support).
- Petition AHPRA to make it mandatory for 'generalists' to provide palliative care services to RACFs.

Data, information management and measurement:
- Improve communication and information flow between GPs, RACFs and the DoH – across the entire system.
- Create a centralised repository for support and information on EOL&PC, VAD and ACP for patients, families and RACF staff.
- Develop projects and processes to encourage and measure meaningful stakeholder feedback and co-design pathways.

Pre Reading 3

Nous Summary of International and National EOL&PC Models and Approaches in RACFs

Government of **Western Australia**
Department of **Health**

National Partnership Agreement for Comprehensive Palliative Care in Aged Care (NPA)
Palliative Care in Residential Aged Care – A Summary of Nous Group's Evidence Assessment

A review of international and Australian approaches to providing end of life and palliative care (EOL&PC) in residential aged care facilities (RACFs) was commissioned by the Australian Government Department of Health and completed by the Nous Group (Nous). The Nous review comprised a rapid evidence assessment of the international (seven models) and national (12 models) peer-reviewed and grey literature. A summary of the findings is presented in the table below and contributes to the evidence-base used by the WA Health End of Life Care Program for future planning.

WA approaches were omitted in the Nous summary (possibly due to the lack of peer reviewed literature). These are represented in an Addendum to the Nous table: Bethesda Health Care's Metropolitan Palliative Care Consultancy Service (MPaCCS) and the Cancer Council of WA's Palliative and Supportive Care Education (PaSCE) approach.

Nous Review Highlights

The Nous review highlights the following key features of successful models/approaches: Case management, capability building, specialist in-reach services, shared care, specialist out-reach services and integrated care.

Nous concludes these success factors "are multi-dimensional but share a common theme of integrating specialist palliative knowledge and/or care into RACFs" . Nous also highlights three models of care that address health interface issues, with strong evidence underpinning their success:

- INSPIRED Model - a case management approach to aid the identification of palliative care needs and provision of clinical assessments. Proactive identification of palliative care needs in a systematic assessment framework and the integration of specialist palliative care with a palliative approach delivered by the RACF were noted as reasons for success.
- NSW Outreach Geriatric Medication Advisory Service - multidisciplinary case conferences involving GPs, geriatricians, pharmacists and residential aged care staff to improve medication management for residents. The evidence indicated that the use of a case conferencing approach is more effective than an individual health provider, and that success may be driven by the presence of the resident's GP and a focus on individual residents with agreed, time-based goals and approaches.
- Envelope Model - used to ensure effective transfer of information during ED transfers. Its ease of use, low cost, and ability to increase awareness of the importance of clinical handovers were noted as reasons for success.

Model of Care	Key element	Description	Why good practice?	Evaluation or review?
AUSTRALIA				
INSPIRED Model[178] **ACT**	Case management	INSPIRED model consists of placing a palliative care nurse practitioner in RACFs. Nurse practitioners conduct 'Needs rounds' to assess residents' palliative care needs and deterioration. Palliative care nurse practitioners provide direct support though clinical assessments and indirect support through needs rounds, which serve to uplift staff capability through care plan discussions.	• Normalised death and dying in RACFs • Provided timely access to palliative care specialist • Reduced unnecessary hospitalisations • Improved decision making and planned care for residents, meaning staff and relatives were better informed on resident trajectory • Developed capabilities of RACF staff indirectly through needs rounds.	A quasi-experimental design in four RACFs. Formal evaluation conducted. Results: • Substantial reduction in the length of hospital stays • Lower incidence of death in the acute care setting.
Lavender Palliative Care Suite -	Integrated care	HammondCare operates a nine-bed specialist palliative care unit as part of a 124-place mixed low and high-care home. Integrated, multi-disciplinary approach to care. Access to	• Enabled personalised and flexible care routines • Provided for residents' individual physical, psychological, social and spiritual needs • Demonstrated efficacy of providing specialised palliative care in an existing residential aged care setting.	No formal evaluation or review identified.

[178] Chapman, M, Johnston, N, Lovell, C, et al., "Avoiding costly hospitalisation at end of life: findings from a specialist palliative care pilot in residential care for older adults," British Medical Journal. 2015.; Johnston, N, Lovell, C, Liu-, W-M, et al., "Normalising and planning for death in residential care: findings from a qualitative focus group study of a specialist palliative care intervention," British Medical Journal. 2016.

Model of Care	Key element	Description	Why good practice?	Evaluation or review?
AUSTRALIA				
Hammond Care[179] **VIC**		HammondCare acute care, clinical training service and in-house pharmacy.		
Geriatric Flying Squad[180] **NSW**	Specialist outreach service	Service provides a rapid response and a clear point of contact for RACF staff to access support. Service provides a comprehensive assessment in the older person's home at the RACF within 2-4 hours of referral, including the provision of palliative care. Expedited ward admission where necessary. Assessment occurs at the person's home in the aged care facility if this is their choice.	• Provided proactive and timely care, in the home where possible • Improved decision support making through risk stratification • Improved care coordination and continuity of care • Developed capability across individuals, units and organisations • Established quality indicators through comprehensive geriatric assessment • Provided access to network of specialist palliative care professionals through partnerships.	No formal evaluation or review identified.
Outreach geriatric medication advisory service[181] **NSW**	Case management	Multidisciplinary case conferences involving GP, geriatrician and pharmacists and residential care staff held for each resident.	• Provided holistic, person-centred care through the multidisciplinary team • Improved appropriate medication prescribing to residents.	A randomised controlled trial in one RACF, for residents with medication problems and/or challenging behaviours. Formal evaluation conducted. Results: • Medication appropriateness improved • Inappropriate prescribing decreased, particularly for benzodiazepines.
Indigenous Palliative Care Service Delivery	Capability building	Created a conceptual model that outlined seven key principles for Indigenous palliative care service	• Developed capabilities of RACF workforce to identify needs specific to Indigenous peoples in Australia.	No formal evaluation or review identified.

[179] Productivity Commission, "Introducing competition and informed user choice into human services: Reforms to human services. Chapter 3: End-of-life care in Australia." 2017.; HammondCare, "Reforms to Human Services submission." 2017.
[180] NSW Agency for Clinical Innovation, "ACI Clinical Innovation Program – Specialised geriatric outreach for residential aged care." 2014.
[181] Crotty, M, Halbert, J, Rowett, D, et al., "An outreach geriatric medication advisory service in residential aged care: a randomised controlled trial of case conferencing," British Geriatrics Society, 33(6). 2004.

Model of Care	Key element	Description	Why good practice?	Evaluation or review?
AUSTRALIA				
Conceptual Model[182] **NT**		delivery: 1) Equity 2) Autonomy and Empowerment 3) The Importance of Trust 4) Humane, Non-judgmental Care 5) Seamless Care 6) Emphasis on Living 7) Cultural Respect.		
Austin Health's Residential InReach service[183] **VIC**	Specialist in-reach service	A geriatrician-led model that operates seven days a week, from 9 AM to 5 PM. This service offers RACFs telephone advice, geriatrician or nursing reviews, acute interventions and palliative care.	• Provided timely access to medical assessment and assistance with clinical decision-making • Improved decision-making around hospital transfers through prioritising and advocating for the resident's best outcomes • Increased documentation of and adherence to advance care plans to assist staff with decision-making and reduce anxiety when a resident deteriorates • Improved staff capacity to engage in advance care planning opportunities in the RACF setting.	No formal evaluation or review identified.
Aged Care Emergency (ACE) program[184] **NSW**	Capability building	ACE supports staff in RACFs to facilitate residents' acute care needs being met within the facility and avoiding an ED presentation. Aim to reduce the need for residents of RACFs to present to an ED for acute care, or where ED presentation is required, to proactively manage the visit. Enhance integration of a range of services for older people.	• Increased respect for knowledge and skills of RACF staff • Provided RACF staff access to a network of specialist palliative care providers • Developed collaborative relationships and trust to enable appropriate decision making • Established clear patient goals of care prior to transferring to an ED • Provided proactive case management within the ED.	Internal review conducted. Results: • An estimated 981 residents avoided ED annually • Compared with usual care, ACE saved an estimated $921,214.

[182] Shahid, S, Taylor, E, Cheetham, S, et al., "Key features of palliative care service delivery to Indigenous peoples in Australia, New Zealand, Canada and the United States: a comprehensive review," BMC Palliative Care, 17(72). 2018.
[183] Amadoru, S, Rayner, J, Joseph, R, et al., "Factors influencing decision-making processes for unwell residents in residential aged care: Hospital transfer or Residential InReach referral?" Australasian Journal on Ageing, 37 (2). 2016.
[184] NSW Agency for Clinical Innovation, "ACI Clinical Innovation Program – Specialised geriatric outreach for residential aged care." 2014.

Model of Care	Key element	Description	Why good practice?	Evaluation or review?
AUSTRALIA				
The Envelope[185] **VIC**	Shared care	A simple tool to transfer clinical information during ED transfers. The Envelope maintained privacy of the resident (no clinical information is recorded on the Envelope), was succinct and simple, and kept costs to a minimum.	• Improved clinical handover, as perceived by staff • Raised awareness of the importance of clinical handover, as perceived by staff.	Quasi-experimental study design. Internal review conducted. Results: • 163/165 staff (99%) thought the Envelope was useful • 148/165 (90%) staff said it was easy to use • 128/165 staff (78%) and all interviewees believed that using the Envelope improved clinical handover • 152/165 staff (92%) indicated they would continue to use the Envelope.
CARE-PACT[186] **QLD**	Specialist in-reach services	Comprehensive Aged Residents Emergency and Partners in Assessment, Care and Treatment (CARE-PACT) program: a hospital substitutive care and demand management project that provides a consultative service for GPs regarding their resident's acute healthcare issues. CARE-PACT is a dedicated, hospital-based, single point of telephone contact for referral of deteriorating RACF residents for GPs, paramedics, RACF staff and community health providers. CARE-PACT partners with existing community and hospital-based services to facilitate linking of	• Optimised continuity of care and effectiveness of discharge with informed collaborative care planning • Improved quality of gerontic nursing care in the ED • Reduced hospital length of stay by having ED receive prior warning of a forthcoming ambulance transfer • Facilitated early discharge through recognising and remediating barriers to discharge early in the presentation.	No formal evaluation or review identified.

[185] Belfrage, M, Chiminello, C, Cooper, D, et al., "Pushing the envelope: clinical handover from the aged-care home to the emergency department." 2009.
[186] Burkett, E, Scott, I, "CARE-PACT: a new paradigm of care for acutely unwell residents in aged care facilities," Australian Family Physician, 44(4). 2015.

Model of Care	Key element	Description	Why good practice?	Evaluation or review?
AUSTRALIA				
		residents with acute care needs to the service best able to fulfill these needs.		
Aged Rapid Response Team (ARRT)[187] **NSW**	Specialist outreach service	ARRT offers an outreach service to RACFs through rapid access medical and nursing community visits and a telephone service for advice regarding resident palliative care.	• Provided timely access to specialist care at home • Prevented unnecessary hospital presentations/admissions • Developed capabilities for registered nurses in RACFs • Increased documentation of advance care planning.	No formal evaluation or review identified.
Virtual Aged Care Services (VACS)[188] **NSW**	Specialist in-reach service	VACS aims to reduce unnecessary hospital presentations and admissions for older people, facilitate early discharge from hospital (reducing length of stay) and streamline older patients' entry points to hospital. VACS was piloted in two RACFs to trial telehealth strategies for delivery.	• Improved care coordination and collaborative care plan development with involved providers • Provided access to a network of specialist care providers • Developed capabilities of RACF staff through education • Increased resource utilisation through telehealth strategies.	Internal review conducted. Results: • ED presentations reduced by 60% • Unplanned admissions reduced to approximately 10% • Two-day reduction in LOS for older people.
St. Vincent's Health Network's Palliative Care Nurse Practitioners[189] **VIC**	Shared care	A network of acute care facilities and specialist palliative care providers that coordinate to deliver palliative care in community and residential aged care facilities.	• Provided timely provision of appropriate care and support • Improved assessment, management and evaluation of patients • Prescribed appropriate medications • Delivered personalised care • Provided continuity of care between hospital and home • Provided advice and support to patients and their loved ones (including care for physical, psychological and spiritual needs).	No formal evaluation or review identified.

[187] NSW Agency for Clinical Innovation, "ACI Clinical Innovation Program – Specialised geriatric outreach for residential aged care." 2014.
[188] Ibid.
[189] Nous Group, "Stocktake and analysis of activities at the interface between the aged care, health and disability systems." 2020; St. Vincent's Health Australia, "Palliative Care Nurse Practitioners." 2019.

Model of Care	Key element	Description	Why good practice?	Evaluation or review?
AUSTRALIA				
REACH Aged Care in the South (REACH)[190] **SA**	Shared care	A program where GPs worked with facilities to assist with residents' urgent needs and ongoing medical services.	• Provided urgent assessment for residents' whose usual GP was unavailable • Provided ongoing medical services to RACF patients • Assisted with facilities clinical governance • Provided education and training and participation in Medical Advisory Committee	Evaluation conducted.. Results: • 111 GPs as practitioners for 750 patients within 6 pilot RACFs • Reduction of unnecessary emergency department transfers within the first 12 months • Inconclusive economic evaluation The program was closed in 2014 because of changes to government funding and subsequent changes to the REACH business model.
BUPA Model of Care[191] **Various jurisdictions**	Integrated care	A program where GPs deliver preventative healthcare and immediate medical treatment in residential aged care facilities.	• Provided individual services in RACFs, including delivery of palliative care • Trained and educated GPs as required	Evaluation conducted. Results: • Unplanned hospital transfers reduced by half • Initial indications that this approach is saving acute care $500,000 per care home annually in unplanned transfers
INTERNATIONAL				
Residential Aged Care Integration Program (RACIP)[192]	Specialist outreach service	RACIP is a quality improvement intervention to support residential aged care staff and includes on-site support, education, clinical coaching and care coordination provided by	• Provided education and clinical coaching through education sessions and access to gerontology clinical coaching • Developed a collaborative relationship between GNSs and facility staff	Randomised control trial. Formal evaluation conducted. Results:

[190] Reed, R, "Models of general practitioner services in residential aged care facilities." Australian Family Physician. 2015.
[191] Ibid.
[192] Boyd, M, Armstrong, D, Parker, J, et al., "Do Gerontology Nurse Specialists Make a Difference in Hospitalization of Long-Term Care Residents? Results of a Randomized Comparison Trial." American Geriatrics Society. 2014.

Model of Care	Key element	Description	Why good practice?	Evaluation or review?
AUSTRALIA				
New Zealand		employed by a large district health board.	guides • Improved care coordination for high-risk residents • Provided access to a network of gerontology specialists, e.g. with secondary care Older Adult Specialists and primary and secondary care services.	intervention increased 59% for the comparison group and 16% for the intervention group • Significantly lower rate change for those admitted for medical reasons for the intervention group (13% increase) than the comparison group (69% increase).
Aged Residential Care Health Utilisation Study (ARCHUS)[193] **New Zealand**	Case management	A complex multi-disciplinary team intervention in long-term care facilities. A GNS conducted baseline facility needs assessment and quality indicator benchmarking. A multi-disciplinary team (MDT) meetings were held involving a geriatrician, facility GP, pharmacist, GNS and senior nursing staff.	• Improved integration of RACF with geriatricians and with emergency/acute services • Educated RACF staff to increase their use of research and current guidelines • Improved RACF palliative care practices • Provided alternative residential aged care models to target care for high risk groups, e.g. those with end-stage dementia.	Formal evaluation conducted. Results: • The intervention did not impact overall rates of acute hospitalisations or mortality (previously published) • Intervention resulted in fewer 'big five' admissions with no significant difference in the rate of other acute admissions • The intervention group were 34.7% less likely to have a 'big five' acute admission than controls.
Gold Standard Framework (GSF)[194] **United Kingdom**	Case management	A model of end-of-life care, in nursing homes in England. The GSF helps practitioners to identify individuals in need of supportive end-of-life care, to assess their needs, symptoms, preferences and other concerns important to them.	• Increased discussion with residents and families about care towards the end-of-life • Improved communication with GP out-of-hours services • Introduced procedures for anticipatory medication and greater staff confidence in caring for people at the end-of-life.	Formal evaluation conducted. Results: • The programme resulted in improved processes for delivering end-of-life care • At follow-up, there were significant changes in the proportions of homes

[193] Foster, S, Boyd, M, Broad, J, et al., "Aged Residential Care Health Utilisation Study (ARCHUS): a randomised controlled trial to reduce acute hospitalisations from residential aged care,"
[194] Badger, F, Clifford, C, Hewison, A, & Thomas, K, "An evaluation of the implementation of a programme to improve end-of-life care in nursing homes," Palliative Medicine, 23. 2009.

Model of Care	Key element	Description	Why good practice?	Evaluation or review?
INTERNATIONAL				
				that had systems for identifying residents in need of end-of-life care, had care coordinators and were routinely undertaking advance care planning • Minimal change in the proportion of homes undertaking discussions about preferred place of care, however these were high at baseline.
The Supportive and Palliative Care Indicators Tool (SPICT)[195] **United Kingdom**	Capability building	SPICT is designed to provide practical, evidence-informed guidance to help clinicians working in primary and secondary care recognise when their patients might be at risk of dying and likely to benefit from supportive and palliative care in parallel with appropriate ongoing management of their advanced conditions.	• Identified patients with multiple unmet needs who would benefit from needs assessment and advance care planning • Provided clear indicators which clinicians can use to initiate conversations with patients and families • Promoted effective communication and coordination between primary and secondary care teams.	Formal evaluation conducted. Results: • Patients who died had significantly more unplanned admissions, persistent symptoms and increased care needs • By 12 months, 62 (48%) of the identified patients had died. 69% of them died in hospital, having spent 22% of their last 6 months there.
Palliative Care Mobile Unit[196] **Canada**	Specialist in-reach services	A palliative care mobile unit to provide care to residents at end of life. Unit contained palliative care specialists (GP and/or Nurse) to identify palliative care needs at the residential facility.	• Families and medical teams supported to manage end-of-life symptoms and psychological suffering • Avoided unnecessary hospitalizations.	No formal evaluation or review identified.

[195] Highet, G, Crawford, D, Murray, S, Boyd, K, "Development and evaluation of the Supportive and Palliative Care Indicators Tool (SPICT): a mixed-methods study," British Medical Journal. 2018.
[196] Basson, B, Vassal, P, Richard, A, *et al.*, "Role of a Palliative Care Mobile Unit in a nursing home," Review Internationale De Soins Palliatifs, 17(2). 2002.

Model of Care	Key element	Description	Why good practice?	Evaluation or review?
INTERNATIONAL				
Palliative Care Leadership Teams (PCLT)[197] **United States**	Capability building	PCLT included recruitment and training of Palliative Care Leadership Teams in each facility, followed by six technical assistance meetings for team members. Hospice providers delivered six educational sessions for all nursing home staff using a structured curriculum.	• Increased hospice enrolment • Improved pain assessment and nonpharmacologic pain treatment • Increased advance care planning discussions.	No formal evaluation or review identified.
Social workers to enhance advance care planning[198] **United States**	Specialist in-reach services	Nursing home social workers were given a baseline education in advance care planning that incorporated small-group workshops and role play/practice sessions for intervention social workers. Social workers than continued care planning with residents of nursing homes, discussing goals of care at team meetings and "flagged" advance directives on nursing home charts.	• Improved documentation of and adherence to residents' preferred resuscitation orders and other medical interventions • Provided indirect capability uplift of nursing home staff to end-of-life needs (e.g. advance care planning) during team meetings.	Randomised controlled trial design. Internal review conducted. Results: • Intervention residents more likely than the control group to have their preferences regarding cardiopulmonary resuscitation (40% vs 20%, P5.005), artificial nutrition and hydration (47% vs 9%, Po.01), intravenous antibiotics (44% vs 9%, Po.01) and hospitalization (49% vs 16%, Po.01) documented in the nursing home chart • Control residents were significantly more likely than intervention residents to receive treatments discordant with their prior stated wishes.

* Extracted from the 2020 Nous Literature Review Summary Report (included in EOLPCAC NPA papers).

[197] Hanson, L, Reynolds, K, Henderson, M, *et al.*, "A quality improvement intervention to increase palliative care in nursing homes," Journal of Palliative Medicine, 8(3). 2005.
[198] Morrison, R, Chichin, E, Carter, J, *et al.*, 'The effect of a social work intervention to enhance advance care planning documentation in the nursing home,' American Geriatrics Society, 52: 290-294. 2005.

ADDENDUM – Exemplar WA EOL&PC Models and Approaches in RACFs

Model of Care	Key element	Description	Why good practice?	Evaluation or review?
WA				
Metropolitan Palliative Care Consultancy Service (MPaCCS)	In-reach specialist service	A multi-disciplinary nurse-led specialist in-reach consultancy service building the capacity and capability of RACF staff to provide safe, high-quality EOL&PC. Tailored capacity building education and training is both patient and facility-based.	• Capacity building – Advice, education, training and clinical mentoring tailored for RACF facility and patient-based needs. • Improved advanced care planning outcomes, symptom assessment and management. • Increased staff confidence. • Improved collaboration and care coordination between RACFs and health services. • Improved information exchange and family/carer involvement in planning and care.	• Contractual evaluation of funder-specified KPIs demonstrating good outcomes.
Palliative and Supportive Care Education (PaSCE)	Education and training	Evidence-based palliative care education and training to increase generalistEOL&PC knowledge and understanding among health professionals, health care workers and palliative care volunteers in all RACF and health settings.	• Building capacity (knowledge, skills and confidence) in delivery and understanding palliative care (generalist), tailored to learner needs with content inclusive of higher risk cohorts (e.g. dementia, CALD, LGBTIQ, Aboriginal people).	• Contractual evaluation of funder-specified KPIs demonstrating good outcomes.

Pre Reading 4

Claiming MBS in RACFs

Practice Assist and Primary Care Resources

Pre Reading 4: Claiming MBS in RACFs

- Please review the attached presentation “Older Adult Health Conditions In Residential Aged Care MBS in RACFs, Practice Assist and Primary Care Resources”

Thank you

Government of Western Australia
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