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

Optimising delivery of the NPA CPCiAC using a program logic approach

Aim

The *National Partnership Agreement for Comprehensive Palliative Care in Aged Care* (NPA CPCiAC) seeks to strengthen national and state efforts to improve end-of-life and palliative care (EOL&PC) for Residential Aged Care Facility (RACF) residents, their families and carers, and links with *The Royal Commission into Aged Care, Quality and Safety* findings. The aim was to identify and deliver projects against the NPA CPCiAC using a program logic approach (PLA).

Method

- **Funding** totalling $11.4M from the Commonwealth and state to fund projects that address NPA CPCiAC criteria.
- **Robust PLA** to map the NPA CPCiAC against WA context and need.
- **Targeted consultation** with key stakeholders.
- **Sector-wide consultation** identified challenges, opportunities and innovation for EOL&PC in WA's RACFs.
- **GP consultation** on primary care, EOL&PC in WA RACFs co-hosted with WA Primary Health Alliance.
- **Identification, development and commissioning** of 9 projects across WA prioritised on need and informed by the PLA and consultation outcomes.
- **Evaluation mechanisms** developed in line with the PLA to capture meaningful performance indicators and demonstrate impact and success.

1. Metropolitan Palliative Care Consultancy Service (MPaCCS) expansion

Expansion of the specialist in-reach model to build RACF staff capability using patient-based care episode and scenario training in the outer east metropolitan region, and support metropolitan-wide coordination and liaison across hospitals and RACFs.

2. Residential Aged Care Excellence in Palliative Care (RACEPC) Communicate

Online targeted education to RACF staff focused on communication, and recognising and responding to the deteriorating resident. Includes virtual methods (for clinical and non-clinical staff), integrated webinars, and AI technologies to enhance user experience.

3. Transition Support Navigator pilot

Pilot in the North Metropolitan Health Service to proactively facilitate integration of care at points of transition for inpatients +65 years referred to Transition Care RACF at time of discharge from hospital. Hospital-based role providing specialist support at key points of transition, and supporting transitional care providers and/or RACFs.

4. Care Coordinator pilot

Two hospital pilots in the South Metropolitan Health Service:

1. Target patients admitted to hospital from an RACF, and discharged to an RACF/Transitional Care Facility for the first time to support transition. Works across all wards and liaises with the Geriatric and Palliative Care teams.

2. Support ACP for patients within the hospital's Comprehensive Care Centre entering a RACF/Transitional Care Facility for the first time.

5. Transition Support Officer pilot

Pilot in the East Metropolitan Health Service to:

1. Work with RACFs with high volumes of hospital presentations and complete audits to guide time-limited quality improvement support for ACP, and support access to ACP during transition between RACF and hospital.

2. Support ACP for hospital inpatients transitioning to RACFs/Transitional Care Facilities for the first time, including transition of information at discharge.

6. GP Case-conferencing Coordinator pilot

Pilot for four Case-Conferencing Coordinators located in metropolitan RACFs to support primary care coordination between General Practice and RACFs, coordinate case conferencing aided by Medicare Benefits Schedule items, and develop systems and processes to be sustainable for GPs and RACFs.

7. Residential Care Line (RCL) expansion

Acute clinical support to RACFs including generalist palliative-related care, symptom management, and identifying need for ACP and Goals of Care discussions. Deliver the Clinical Deterioration education package to upskill RACF clinical staff on recognising and responding to the deteriorating resident.

8. GP information resources

Toolkit/business model to support GPs to access and deliver services in RACFs, with mentoring from existing RACF GPs. The aim is to support GPs with information and resources to enhance their business and care provision in an RACF setting.

9. Residential Goals of Care (RGoC)

Adapt the Goals of Care form and process used in hospitals to RACFs, and pilot in WA Country Health Service RACFs. The tool supports clinical care, provides common language across settings, and complements ACP.

Findings

- A congested landscape resulted in challenges to development and implementation of projects. This included the impacts of COVID-19, and initiatives from a range of entities competing for RACF and GP time also looking to address Royal Commission findings.
- Data indicates the innovative models identified using the PLA are benefitting ACP, care coordination, and education access at RACFs, with some projects in early implementation due to the challenges.

Conclusions

- Challenges required projects to be innovative and agile to create or adapt models that met the need of WA RACFs, providers and the community in the current climate.
- The PLA optimised the identification and development of projects that expanded evidence-based models of care and/or supported innovative approaches to embed quality EOL&PC and was key in supporting responsiveness.

Presenter: Mrs Frances Arthur, Senior Project Officer – End of Life Care Program, WA Department of Health

Authors: Mrs Frances Arthur, WA Department of Health; Ms Gabriella Jerrat, WA Department of Health

CED-014543-A/0723