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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Quality Improvement Toolkit

For General Practice

Palliative and End-of-Life Care

Introduction

The Quality Improvement Toolkit

This Quality Improvement (QI) toolkit comprises modules specifically crafted to assist your practice in achieving straightforward, quantifiable, and sustainable enhancements to deliver optimal care for your patients. Utilising the Model For Improvement (MFI), the toolkit facilitates the completion of QI activities.

As you progress through the modules, you'll receive guidance on exploring your data to gain deeper insights into your patient population and the care pathways within your practice. Insights gathered from module activities and related data will shape improvement ideas, which you can implement using the MFI.

The MFI employs the Plan-Do-Study-Act (PDSA) cycle, a proven method for effecting successful change. It presents several advantages:

- A straightforward approach applicable to anyone
- Reduced risk through starting with small-scale changes.
- Effectiveness in planning, developing, and implementing impactful changes.

The MFI assists in breaking down the implementation of changes into manageable components. These components are then systematically tested to ensure that the changes lead to measurable improvements, minimizing wasted effort.

If you would like additional support in relation to quality improvement in your practice, please contact practicesupport@cesphn.com.au

As research and health guide
lines continually evolve, the information in this document will need to be updated. If you have any feedback on the content of this document, please reach out to Central and Eastern Sydney PHN.

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Acknowledgements

Central and Eastern Syndey PHN (CESPHN) acknowledges the Aboriginal and Torres Strait Islander peoples of this nation. We acknowledge the Traditional Custodians and Sovereign People of the land across which we work. We recognise their continuing connections to land, water and community and pay respect to Elders past present and emerging.

CESPHN would like to acknowledge that much of the source material for this workbook was originally created by Brisbane South Primary Health Network (BSPHN). Further material was sourced from an adapted version by North Western Melbourne Primary Health Network (NWMPHN).

Some material contained in this workbook has been extracted from organisations including Australian Bureau of Statistics, Australian Institute of Health and Welfare, Royal Australian College of General Practitioners, Australian Government Department of Health, Australian Journal of General Practice, and Polar. These organisations retain copyright over their original work, and we have abided by licence terms. Referencing of material is provided throughout.

The information in this workbook does not constitute medical advice and neither BSPHN, NWMPHN nor CESPHN accept any responsibility for information in the way this workbook is interpreted or used.

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Palliative Care and End of Life Care

Palliative care helps people live their life as fully and as comfortably as possible when living with a life-limiting or terminal illness. It is patient centered care that allows health professionals to identify and treat any physical, emotional, spiritual, or social symptoms. Accessing palliative care doesn't exclude people from receiving clinical interventions and therapies where appropriate [1]. There has been a long-term misconception that palliative care is only for cancer patients, resulting in disproportionate access in favor of cancer patients, despite non-malignant life-limiting illnesses having a similar symptom burden[2]. Anyone suffering from an active, progressive, or advanced illness such as end stage heart, lung and kidney disease, neurological conditions and end stage dementia can benefit from the provision of palliative care[1]

Early access to palliative care can help people living with chronic complex illnesses have a better quality of life[3] . General practitioners play an important role in the provision of palliative care and are well placed to identify their patients palliative care needs as they often have established relationships[4] . Engaging in advance care planning allows individuals to anticipate and prepare for future episodes of illness, including making provisions for end-of-life care.

A palliative approach which comprises management of the underlying condition and attention to symptoms, psychosocial needs and carer support has recognised benefits. A palliative approach to care can be considered, discussed, and agreed upon at any point in a patient's illness trajectory[5]. General Practitioners are encouraged to have a proactive systematic approach to end-of-life care built around anticipating their patients' clinical needs and care preferences [5]. The diagram below provides a framework for end-of-life care in the community which supports GPs to:

- use available tools
- assess palliative care needs
- develop proactive person-centered management plans that reduce the need for decision making in emotionally charged situations [(5)].

[1] NSW Government (2023). Palliative care aims to improve quality of life.

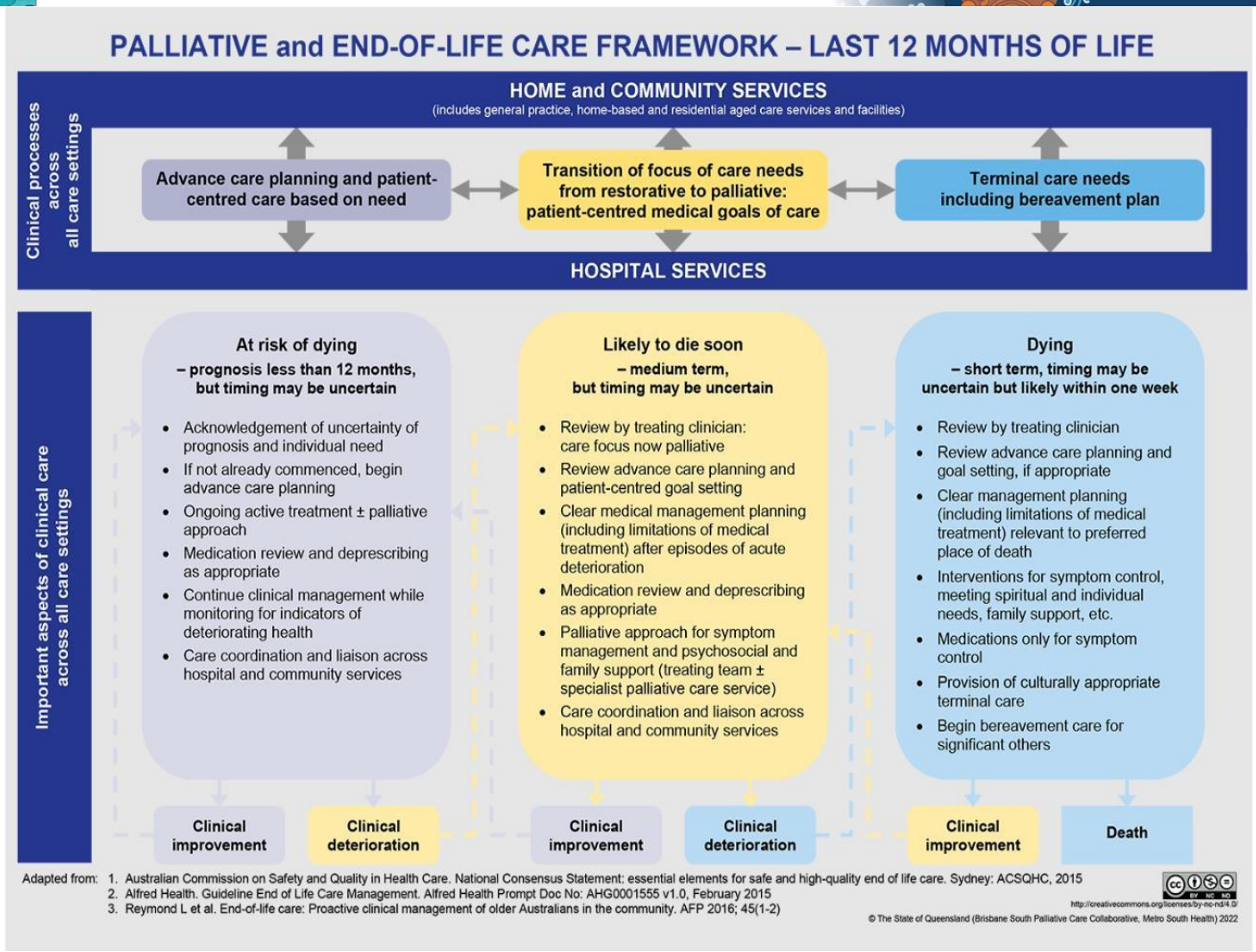
[2] Mounsey, L., Ferrer, M., & Eastman, P. (2018). Palliative care for the patient without cancer. *Australian Journal General Practice,* 47(11), 765-769. DOI: 10.31128/AJGP-07-18-4625

[3] Wiseman, H (2016). Palliative care if for people with chronic disease, not just cancer. Palliative Care Australia

[4] Jones, R., Dale, J., & MacArtney, J. (2023). Challenges experienced by GPs when providing palliative care in the UK: a systematic qualitative literature review. *BJGP Open,* 7(2). doi: 10.3399/BJGPO.2022.0159

[5] Royal Australian College General Practitioners. (2022). Aged care clinical guidelines (Silver Book): Palliative and end-of-life care.

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6 https://metrosouth.health.qld.gov.au/sites/default/files/content/end-of-life-care-framework.pdf

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Topics that will be included in this toolkit include:

- Chronic Complex Illness
- Important conversations including interpreter services
- Assistance to live at home longer
- Palliative Care Teams
- MBS items
- Marking patients as deceased
- Resources

How to use the toolkit

There are checklists included in this toolkit to

you and your practice in assisting patients with palliative and end of life care needs. This includes:

- Planning and preparation
- identifying a sample group of patients
- setting timelines to achieve your goals
- implementing improvement actions
- Documenting your QI activities
- reviewing your QI activities and evaluate if your process is working

Benefits of using the toolkit

The toolkit provides:

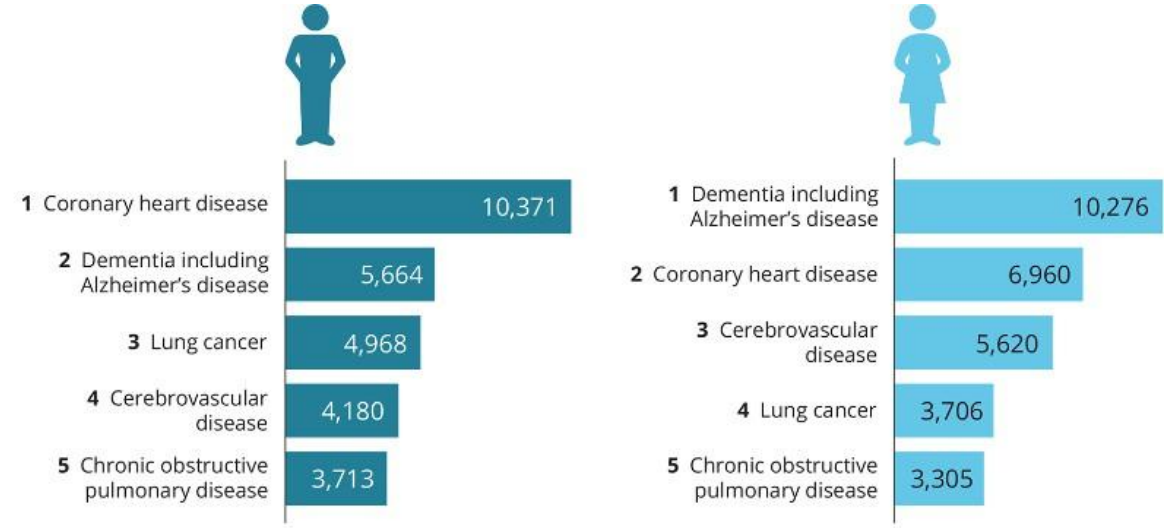
- A structured, easy, and quick approach to implement quality improvement activities.
- A step-by-step guide
- Suggestions to identify suitable patients using data extraction tools.
- Links to prefilled templates and resources.
- Flexibility: activities can be started at any time of the year, and practice teams decide whether to implement a single improvement intervention, or a bundle of interventions.

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Chronic Complex Illness

Chronic conditions are the leading cause of illness, disability, and death in Australia and are generally characterised by long-lasting and persistent effects. End-of-life planning is particularly important for people with complex and chronic health conditions[7] and should occur before conditions progress to later stages where a person's ability to make end-of-life choices may be impeded. The Australian Institute of Health & Welfare commonly reports on 10 major chronic conditions: arthritis, asthma, back problems, cancer, chronic kidney disease, selected heart, stroke and vascular disease, chronic obstructive pulmonary disease, diabetes, osteoporosis, and mental health and behavioural conditions (including mood disorders, drug problems and dementia).

Leading underlying causes of death in Australia, by sex, 2021



Source: AIHW National Mortality Database; Table S3.1.

[7] Agency for Clinical Innovation (2023). End of life planning and palliative care

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Stages of a chronic condition

There are different stages for chronic conditions:

- well (no condition)
- at risk of developing
- undiagnosed
- diagnosed
- high risk and complex
- advanced.

How common are chronic conditions?

Chronic conditions vary from minor issues such as short-sightedness and minor hearing loss to more severe and limiting complaints like musculoskeletal conditions and to potentially life-threatening illnesses such as cancer and coronary heart disease.

In the 2022 National Health Survey, 1 in every 2 Australians (49.9%) reported having at least one chronic condition (i.e. arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, or mental health conditions). The most common reported chronic illness was mental or behavioural conditions (26.1%)[8]. Females were more likely to have at least one chronic condition (52.3%) compared to males (47.4%). The National Health Survey data further indicated that 20% of all Australians, and half of Australians (51%) aged over 65 years, had two or more chronic conditions[7].

The ten identified chronic conditions contributed to nearly 9 out of 10 (89%) deaths in 2021 according to the National Mortality Database and Australia Burden of Disease Study 2022. These conditions also contributed to around 64% of the total burden of disease (fatal and non-fatal) in 2022 (excluding osteoporosis)[9]

Over one third (38%) of the burden experienced by the population could be prevented by reducing the exposure to modifiable risk factors (including both behavioural and biomedical risk factors). In 2018 the risk factors causing the most burden were tobacco use (8.6%), high body mass (8.4%), and alcohol use (4.5%)[8]. Among Aboriginal and Torres Strait Islander people half the burden (49%) is attributed to modifiable risk factors, but the risk factors remained the same, tobacco (11.9%), alcohol use (10.5%) and high body mass (9.7%)[10].

[8] Australian Bureau of Statistics. (2023). Health conditions prevalence

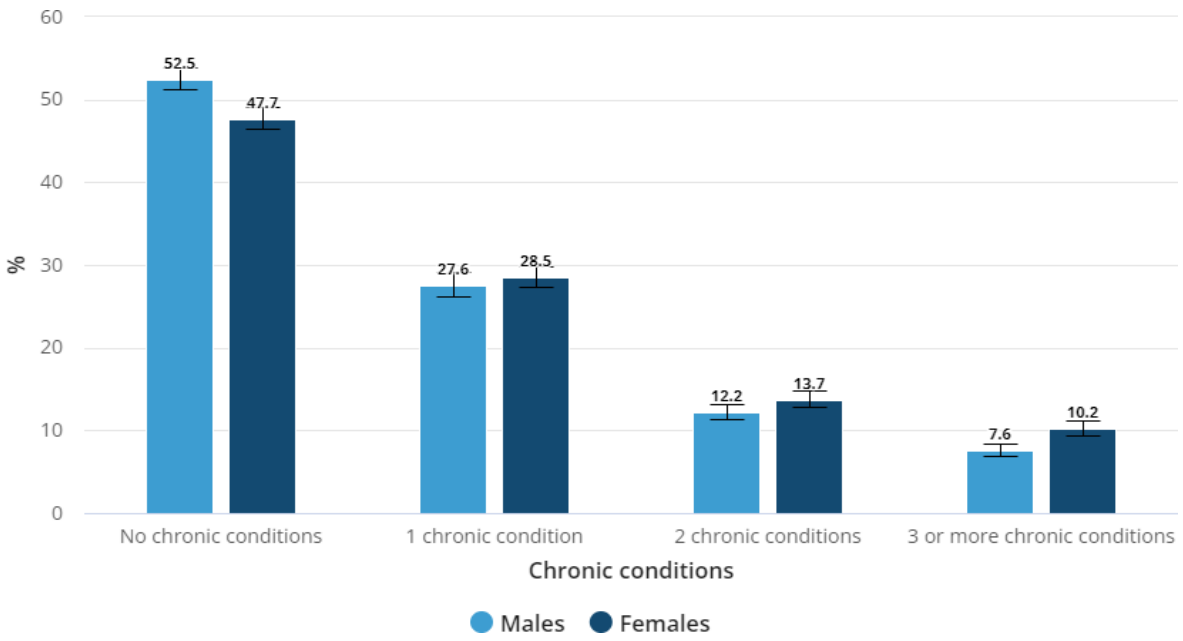
[9] Australian Government- Australian Institute of Health and Welfare. (2022). Australian Burden of Disease Study 2022

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Aboriginal and Torres Strait Islander people are faced with poorer health, worse health outcomes and experience a burden of disease 2.3 times greater than non-Indigenous Australia's[9]. In addition, the age-standardised death rate from coronary heart disease, diabetes and COPD is 2.0 times, 4.8 times and 3.2 times higher respectively than non-Indigenous Australians[11]. Life expectancy at birth for Aboriginal and Torres Strait Islander males is 8.8 years less than non-Indigenous males and for Aboriginal and Torres Strait Islander females it is 8.1 years less than non-indigenous females. Chronic disease is one of the main factors behind the gap in life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians[12].

Earlier detection and better treatments which often lead to people living longer with their chronic conditions as well as an ageing population are all recognised as attributing factors to the increased prevalence of chronic disease. Behavioural factors, such as smoking, alcohol consumption or poor diet also increase the risk of developing chronic conditions.

Number of chronic conditions experienced by sex and age, 2022. (7)



[10] Australian Institute of Health and Welfare. (2022). Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torress Strait Islander people 2018.

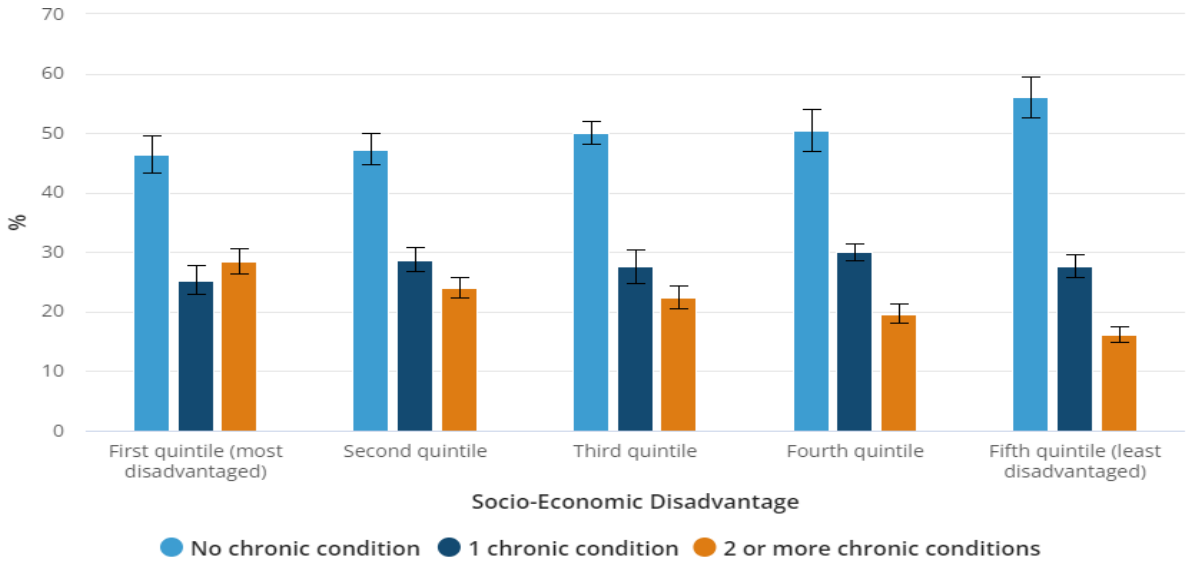
[11] Australian Government-Australian Institute of Health and Welfare (2023). Deaths in Australia.

[12] Australian Bureau of Statistics. (2023). Aboriginal and Torres Strait Islander life expectancy.

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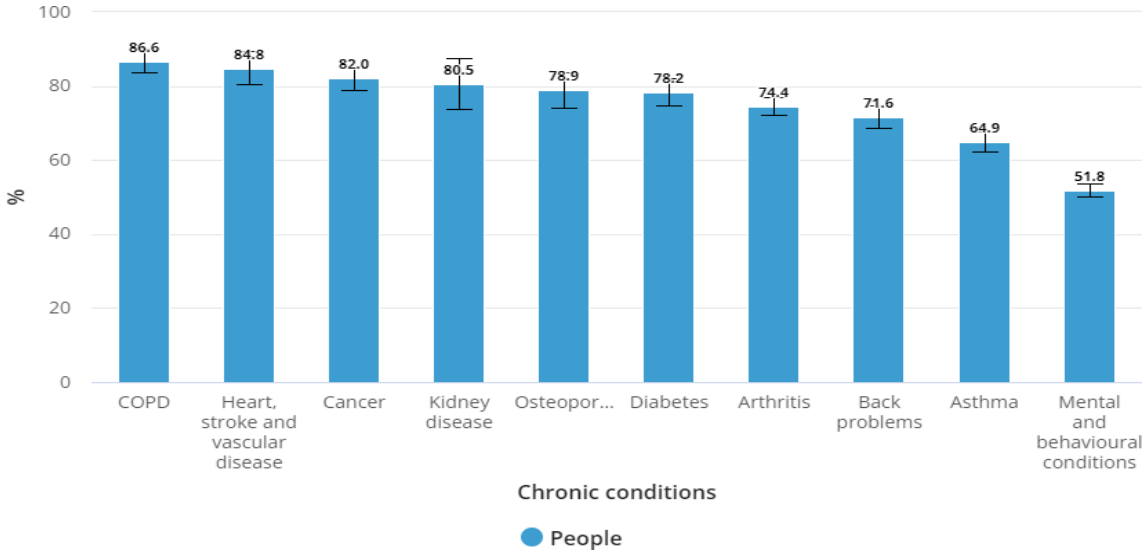
Number of chronic conditions experienced by socioeconomic disadvantage 2022.

Almost one in three (28.4%) people living in areas of most disadvantage had two or more chronic conditions, compared to one in eight (16.1%) of those living in areas of least disadvantage[7].



a. A lower index of Disadvantage quintile (e.g. the first quintile) indicates relatively greater disadvantage and a lack of advantage in general. A higher Index of Disadvantage (e.g. the fifth quintile) indicates a relative lack of disadvantage and greater advantage in general. See Socio-Economic Indexes for Areas (SEIFA), Australia, 2016 (abs.gov.au).

Proportion of people with multimorbidity by type of chronic condition, 2022 (7)



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Activity 1 – Understanding your patient population

Activity 1.1 – Data collection from Polar

Complete the below table by collecting data from your Polar Data Extraction Tool.

The objective of this activity is to gather data to identify the number of patients with a complex medical condition.

Activity Table 1: Collect Polar data (patients with a complex medical condition)

* RACGP defines 'active' patients as those visiting three or more times in two years. The searches below do not capture those patients who may come in for screening every two years, or twice in two years. We have therefore provided a column to capture all patients with complex medical conditions. To capture all patients in recipe provided, DO NOT select the 'Active (3x in 2yrs)' tick-box.

For a guide to how to extract the Polar data for this toolkit please follow this toolkit guide or the Education Portal.

	Description	Total number of active patients
1.1a	Number of active patients	
1.1b	Number of active patients with Congestive heart failure	
1.1c	Number of active patients with COPD	
1.1d	Number of active patients with Dementia	
1.1e	Number of active patients with chronic renal failure	
1.1f	Number of active patients with cancer	
1.1g	Number of active patients with a BMI < 20	
	Use this link for polar guide or use Polar Education Portal to identify the data required. If you need assistance contact your Digital Health Officer digitalhealth@cesphn.com.au	

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Reflection comments for **Activity 1.1:** Does anything surprise you? Is this what you expected?

Practice name:	**Date:**
Team member:	

Activity 1.2 – Data collection form Polar – Identifying RACGP active patients with a chronic condition, who have a current GPCCMP and may benefit from screening for palliative care needs.

Fill in the table below with information gathered from Polar data extraction tool. For step-by- step instructions, access the guide or the Education Portal.

The objective of this activity is to gather data to identify RACGP active patients with a chronic condition, who have a current GPMP and may benefit from screening for palliative care needs.

	Description	Total number
1.2a	Number of active patients with heart failure who have a current GPCCMP.	
1.2b	Number of active patients with COPD who have a current GPCCMP.	
1.2c	Number of active patients with Dementia who have a current GPCCMP.	
1.2d	Number of active patients with CKD who have a current GPCCMP.	
1.2e	Number of active patients with Cancer who have a current GPCCMP.	
	Use this link for polar guide or use Polar Education Portal to identify the data required. If you need assistance contact your Digital Health Officer digitalhealth@cesphn.com.au	

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Reflection comments for **Activity 1.2:** Does anything surprise you? Is this what you expected?

Practice name:	**Date:**
Team member:	

Activity 1.3 – Understanding your practice chronic disease population

The aim of this activity is to increase your understanding of the active complex chronic disease patient population.

Description	Status	Action to be taken
After completing **activity 1.1** are there any unexpected results with your practice's complex chronic disease patient population?	☐ Yes: **see actions to be taken** ☐ No: continue with activity	Please explain: (for e.g. higher diabetes population than expected, practice has a low population of people with cardiovascular disease) How will this information be communicated to the practice team?
After completing **activity 1.2** are there any unexpected results with your practice's comorbidities population?	☐ Yes: **see actions to be taken** ☐ No: continue with activity	Please explain: (for e.g. high number of people with 3 or more chronic conditions) How will this information be communicated to the practice team?
After reviewing your patient chronic disease population, are there any changes you	☐ Yes, **see actions to be taken to help set you goals.**	Refer to the Model for Improvement (MFI) and the

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would like to implement in the practice, to help manage patients, over the next 12 months?	☐ No, you have completed this activity	Thinking part at the end of this document. Refer to the Doing part-PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection comments for **Activity 1.3:** Does anything surprise you? Is this what you expected?

Practice name:	**Date:**
Team member:	

Best practice tools to support the early identification of End-of-Life patients

- SPICT TOOL/Surprise Question- Supportive & Palliative Care Indicators Tool is a clinical tool to help identify people with deteriorating health and prompt holistic assessment and future care planning.

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Activity 2 - Important conversations

Advance Care Planning

Advance Care Planning is an important process that helps patients plan for future care. It is based on the fundamental principles of self-determination, dignity, and the avoidance of suffering. Through a process of reflection, discussion, and communication the patient is enabled to plan for their future treatment and other care, for a time when they are not competent to make or communicate decisions for themselves.

The process is collaborative and coordinated and involves the person, their families and a multidisciplinary health care team working together to optimise the persons current treatment, care and quality of life and ensuring their needs and wants are met in the future[13].

Central and Eastern Sydney PHN advance care planning QI toolkit

Central and Eastern Sydney PHN have a dedicated advance care planning toolkit.

Important conversations for non-English speaking patients

It is important to use an interpreter when required for these conversations to ensure that the patient's wishes are correctly recorded. An interpreter can be arranged via Translating and Interpreting Service (TIS) . For patients who do not speak English the Appointment Reminder Translation Tool (available online) allows you to translate appointment details into your patient's language.

Activity 2.1 – Activity – Advanced care documentation

The aim of this activity is to ensure relevant people in your practice know the importance of end-of-life conversations and planning.

Description	Status	Action to be taken
Do all relevant practice team members know where to locate advanced care planning documentation?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Advance care planning documentation can be found by clicking the link How will this information be communicated to the relevant practice team members?

[13] https://www.advancecareplanning.org.au/home

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Do any of the practice team require training/assistance on having end of life conversations?	☐ Yes: **see actions to be taken** ☐ No: continue with the activity	Training available at End-of-Life Essentials Or CareSearch Health Professionals How will this information be communicated to the practice team?
After reviewing your end-of-life conversations/ documentation processes, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken to help set you goals.** ☐ No, you have complete d this activity	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to Doing part- PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection comments for **Activity 2.1:** Does anything surprise you? Is this what you expected?

Practice name:	**Date:**
Team member:	

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Activity 3 - Assistance for patients to live at home longer

Living in Their Own Home

As people age most individuals prefer to remain living in their own home surrounded by things they know, near friends and neighbours, and in communities in which they belong. If provided the right support at the right time people can maintain their independence and quality of life, preserve their dignity, and keep themselves connected as they grow older. Despite statistics which indicate an overwhelming majority of Australian's wanting to die at home, very few actually get to do so. This represents a service gap that general practitioners are optimally placed to address[14]. Death and dying is more institutionalised in Australian than most other countries and between now and 2066 deaths are expected to nearly triple from 163,300 per year to more than 430,000 per year[15]. This means the Australian healthcare system must shift away from a hospital-centric treatment of death and dying and move towards better supporting people who wish to receive care at home during their last months of life[5].

My Aged Care

My Aged Care is a service that provides assistance for people aged 65 years and older. This includes:

- Help at home- if someone is finding it harder to do things they use to do, they can ask for some help.
- Short-term care- can help you cope with life's interruptions.
- Aged care homes- if someone is at the stage where they no longer feel able to live independently at home, even with supports that it may be time to consider moving into an aged care home.

Support at Home – End of Life Pathway

The End-of-Life Pathway has been established to support older people who wish to die at home by providing funding for in-home aged care services for individuals who have been diagnosed with a life expectancy of three months or less.

A total of $25 000 is available per eligible participant over a 12 week period.

[14] Reymond, L., Parker, G., Gilles, L., & Cooper, K. (2018). Home-based palliative care. *Australian Journal of General Practice,* 47(11). doi: 10.31128/AJGP-06-18-4607

[15] Swerissen, H., & Duckett, S. (2014). Dying well. Grattan Institute

5 Royal Australian College General Practitioners. (2022). Aged care clinical guidelines (Silver Book): Palliative and end-of-life car

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Eligibility criteria

An older person is eligible to access the End-of-Life Pathway if they meet the following criteria:

- A doctor or nurse practitioner advising estimated life expectancy of 3 months or less to live, and
- Australian-modified Karnofsky Performance Status (AKPS) score (mobility/frailty indicator) of 40 or less (see page 4 for more information on AKPS on this fact sheet).

The End-of-Life Pathway is available to participants already accessing Support at Home services as well as older people not currently accessing services.

How do GP's support patient to access the End-of-Life Pathway?

You will need to fill in and sign an End-of-Life Pathway form for your patient. The End-of-Life Pathway form captures the medical eligibility for accessing the pathway. This will include details of their prognosis and their Australian-modified Karnofsky Performance Status (AKPS) score.

General practitioners can refer individuals to this pathway via this referral form.

How do I submit the End-of-Life Pathway form?

If your patient is already receiving in-home aged care services through Support at Home, you can provide a copy of the signed form to your patient's carer or representative, who can provide it to their aged care provider.

If your patient is not currently receiving in-home aged care services through Support at Home, you can:

- complete and sign a copy of the End-of-Life Pathway form and upload through the 'Make a Referral' or 'GP e-referral' channels (this triggers a request for an aged care assessment)
- complete and sign a hard copy of the End-of-Life Pathway form and give it to the patient's carer or representative to submit. They will then need to contact My Aged Care to request an assessment, or they can use the My Aged Care Apply Online tool.

If you are unsure whether your patient is currently receiving aged care services, please provide them with a copy of the signed End-of-Life Pathway form and ask them to contact My Aged Care on 1800 200 422 for assistance.

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National Disability Insurance Scheme (NDIS)

The NDIS is Australia's first national Scheme for people with disability. It provides funding directly to individuals. This funding can then be used to receive supports and services that help individuals stay living in their own home.

Medical APPS

There are several apps that health professionals can access for a palliative care approach including:

- caring@home app - this app assists health professionals supporting families and carers to help manage symptoms of a palliative care patient who chooses to be cared for, and die, at home if possible. There are resources, in English and nine other languages, for both carers (including training videos) and health professionals.

- palliAGEDgp app - this app provides nurses and GPs with easy and convenient access to information to help them care for people approaching the end of their life.

- palliMEDS app - developed by NPS MedicineWise, this app familiarises primary care prescribers with eight palliative care medicines that have been endorsed by the Australian & New Zealand Society of Palliative Medicine (ANZSPM) for management of terminal symptoms.

Activities of daily living – Health Assessments

Under the Medicare Benefit Schedule (MBS), GPs can complete Health Assessments on all patients aged 75 years and older, 55 years and older for Aboriginal and Torres Strait Islander patients. As part of this assessment GPs and Nurses are to assess the patient's physical function, including the patient's activities of daily living, and whether the patient has had a fall in the last 3 months.

For more information on health assessments, please refer to the MBS Criteria , My Aged Care National Screening and Assessment Form and/or the RACGP Silver Book

Activity 3.1 – Activity – Assistance for patients to live at home longer

The aim of this activity is to ensure relevant people in your practice know who to refer patients to for assistance to live in their own home longer.

Description	Status	Action to be taken
Do all relevant practice team members know who to refer patients to get assistance to live in their own home longer?	☐ Yes: continue with the activity	Refer to the MyAged Care website: MyAgedCare

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	☐ No: **see actions to be taken**	How will this information be communicated to the relevant practice team members?
After reviewing your assistance for patients to live at home longer processes, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken to help set you goals.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part-PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.
Are all health professionals aware of the various medical apps available to download to assist with management of patients?	☐ Yes: continue with activity ☐ No: **see action to be taken**	Please refer to the SPICT tool, caring@home, palliAGEDgp palliMEDS

Reflection comments for **Activity 3.1:** Does anything surprise you? Is this what you expected?

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Team member:	

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Activity 4 – Palliative Care Teams

Effective communication and collaboration are essential when providing palliative and end of life care, otherwise patients can receive incongruent information and inadequately coordinated care. Effective teamwork is also vital in strengthening against moral distress. All care that is provided by the interdisciplinary team should align with the expressed wishes of the patient and seek to maintain or improve quality of life.

Palliative Care Team Members

Palliative care is provided by a team of healthcare professionals with a range of skills. The role of the palliative care team is to relieve any suffering experienced by patients and their families through a comprehensive assessment and treatment of physical, psychosocial, and spiritual symptoms.

The members of the palliative care team may include:

- doctors
- nurses
- allied health professionals
- volunteers
- carers

More information about palliative care services available in the CESPHN region:

Sacred Heart Health Service
Calvary Specialist Palliative Care
Prince of Wales Palliative Care
Sutherland Hospital Palliative Care
St George Hospital Palliative Care
Concord Hospital Palliative Care
RPA Palliative Care

Palliative Care on HealthPathways

HealthPathways (Sydney and South Eastern Sydney) is an online local health information portal to support local GPs and health professionals to the point of consultation. It provides clinical decision support frameworks on how to assess and manage medical conditions, and how to appropriately refer patients to local services and specialists in the most efficient way.

- For assistance with access to Sydney HealthPathways, email SLHD- HealthPathways@health.nsw.gov.au
- For assistance with access to South Eastern Sydney HealthPathways, email SESLHD- HealthPathways@health.nsw.gov.au

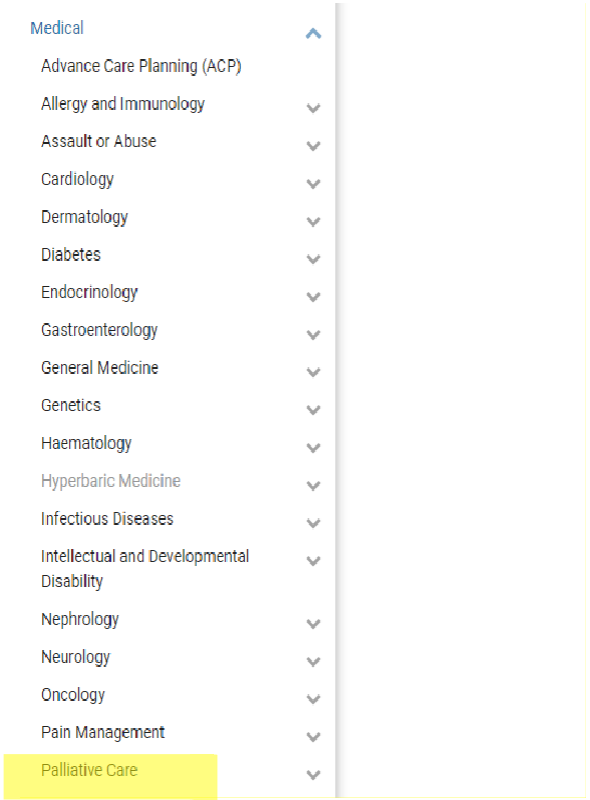
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HealthPathways is a useful tool for accessing information to assist with managing your palliative care patients. It boasts a range of benefits including:

- Best available information on how to assess and manage common clinical conditions, including when and where to refer patients.
- Easy online access to clinical and patient resources for in-consult use, peer-reviewed and localised to our region.
- Integrated, concise, and saving you time

Sydney Local Health District

Palliative Care pathways can be found under Medical on the left-hand side menu bar.



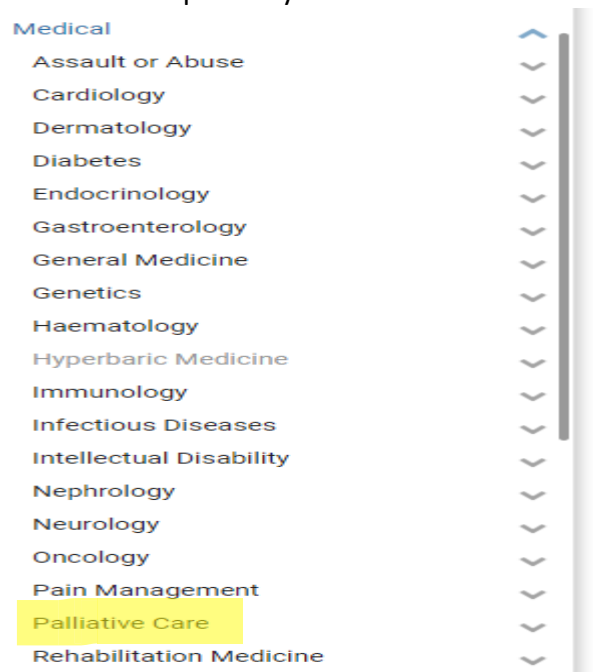
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Within the palliative care pathway, you will find a range of information.



South Eastern Sydney Local Health District

Palliative Care pathways can be found under Medical on the left-hand side menu bar.



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Within the palliative care pathway, you will find a range of information.



Activity 4.1 – Activity – Palliative care teams

Description	Status	Action to be taken
Do all relevant practice team members know who to refer a patient to for Palliative care services?	☐ Yes: continue with the activity ☐ No: **see actions to be taken**	Sacred Heart Health Service Calvary Specialist Palliative Care Prince of Wales Palliative Care Sutherland Hospital Palliative Care St George Hospital Palliative Care Concord Hospital Palliative Care RPA Palliative Care How will this information be communicated to the relevant practice team members?
Do all relevant practice team members know how to access Health Pathways	☐ Yes: **see actions to be taken**	Refer to SouthEasternSydneyHealthPathways or

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end of life/palliative care resources? After reviewing referral process, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ No: continue with the activity ☐ Yes**, see actions to be taken to help set you goals.** ☐ No, you have completed this activity	SydneyHealthPathways How will this information be communicated to the practice team? Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part- PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection comments for **Activity 4.1:** Does anything surprise you? Is this what you expected?

Practice name:	**Date:**
Team member:	

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Activity 5 - Medicare Benefit Schedule (MBS) items

The new Medicare Benefits Schedule (MBS) Level E items for general attendance consultations of 60 minutes or more by general practitioners (GPs) and medical practitioners (MPs) is now available. 21 new items will be included in the MBS for GP and MP Level E consultations of 60 minutes or longer. The new Level E consultation items will improve patient care outcomes by allowing GPs to provide longer consultations to patients where clinically required. This will allow better management of care of patients with chronic conditions and complex care needs such as, but not limited to, patients with multiple chronic conditions, **patients in need of advanced care planning, palliative care, and end of life care**[16].

The following Medicare item numbers may be used for palliative/end of life patients. Visit Caresearch- remuneration for palliative care services for further information.

Health Assessments (items 701-707, 715)

A health assessment is the evaluation of a patient's health and wellbeing. Eligible practitioners use it to help decide if a patient needs:

- preventive health care
- education to improve their health and wellbeing

Please refer to the MBS online for more information on 75+ Health Assessments and Aboriginal & Torres Strait Islander Health Assessments

Home Medication Reviews (item 900)

According to the Quality use of medicines to optimise ageing in Older Australians resource, as our population ages, more people are living with multiple chronic diseases with an associated increase in polypharmacy (multiple medicines use). Medicines use is a complex balance between managing disease and avoiding medicines related problems.

GPs can claim a Medicare item number to complete a Home Medication Review in conjunction with a community pharmacist. Please refer to the MBS online on Home Medication Reviews

General Practice Chronic Conditions Management Plans (items 965 & 967)

Older people experience complex diseases that are dynamic in nature requiring a range of interventions and support approaches at different times through the ageing journey. One approach

[16] Australian Government-Department of Health and Aged Care. Introduction of new Level E consultation items lasting 60 minutes or more.

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is to complete a GP Chronic Conditions Management Plan. Please refer to the MBS toolkit for more information.

Practice nurse chronic disease (item 10997)

Item 10997 may be claimed by a medical practitioner, where a monitoring and support service for a person with a chronic disease care plan (GPCCMP) is provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of that medical practitioner. This item can be claimed up to 5 times in a calendar year.

Full details about the criteria and how to ensure this is met can be found at MBS Online

Case conferences (item 739)

Case conference item number 739 is available to provide the opportunity for holistic, informed approach to ongoing care for providers, carers, and family. The case conference needs to

- be organised by the GP;
- 20 to 40 minutes duration;
- Requires the GP and at least 2 other health care providers to be present

Full details about the criteria and how to ensure this is met can be found at MBS Online

Mental Health treatment plan (if relevant)

There are a number of Medicare item numbers available for GPs to claim for mental health related consultations. Always refer to the Medicare Benefit Schedule for full details. The item numbers include:

Item Description	Medicare Criteria	Frequency of claiming
Mental Health Consultation	Mental health consultation lasting at least 20 minutes. To claim this, the patient does not need to be on a Mental Health Plan.	No limits to the amount of times this item number is claimed
Mental Health Plan	A mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities The Mental Health Plan must include documenting the	A new plan can be completed every 12 months & at least 3 months after claiming an item 2712 – review Mental Health Plan

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	(results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Treatment Plan	After plan has been completed, the patient is entitled to up to 10 Medicare subsidised visits with a Psychologist per calendar year
Review Mental Health Plan	The review item is a key component for assessing and managing the patient's progress once a GP Mental Health Treatment Plan has been prepared, along with ongoing management through the GP Mental Health Treatment Consultation. A patient's GP Mental Health Treatment Plan should be reviewed at least once.	Can be claimed every 3 months or at least 4 weeks after claiming the Mental Health Plan item number

Medicare item numbers for patients in a residential aged care Home

Patients in a residential aged care homes may be eligible for the following Medicare item numbers.

Comprehensive medical assessments (item 701-707)

This health assessment is available to new residents on admission into a residential aged care homes. It is recommended that new residents should receive the health assessment as soon as possible after admission, preferably within six weeks following admission into a residential aged care home. The item number can then be claimed every 12 months.

More information can be found at MBS Online

Care plan contribution (item 731)

GPs can be requested to contribute to eligible multidisciplinary care plan, prepared by RACH or other provider.

GP's contribution is to give advice, prepare part of the plan or amendments to the plan, and add a copy to the resident's medical records.

Where clinically indicated, on submission of item 731 claim, residents may be eligible to access five allied health services in addition to those funded by RACH.

This item number can be claimed every three months, recommended every six months. More information can be found at MBS Online

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Residential Medication Management Review (item 903)

A RMMR is a review of medications in collaboration with the pharmacist report, for residents at risk of medication-related problems or significant change in medical condition. GP initiates RMMR with an accredited pharmacist for permanent residents (new or existing)

This item number can be claimed once every 12 months. More information can be found at MBS Online

Case conference -see information above

Mental Health treatment plans-see information above

Activity 5.1 – Data Collection from Polar

Complete the below table by collecting data from Polar. Instructions on how to do this can be found at: MBS items or MBS attendance or via this guide.

	Description	Total
5.1a	Number of health assessments claimed	
5.1b	Number of Home Medication review claimed	
5.1c	Number of Residential Medication reviews claimed	
5.1d	Number of GP Chronic Conditions Management Plans claimed	
5.1f	Number of Nurse chronic disease item numbers claimed	
5.1g	Number of Aboriginal and Torres Strait Islander assessments claimed in the past 12 months	
5.1h	Number of Mental Health item numbers claimed	
	Use this link for polar guide or use Polar Education Portal to identify the data required. If you need assistance contact your Digital Health Officer digitalhealth@cesphn.com.au	

Please note*: You may wish to change the dates of your searches to compare previous years &/or different time frames. You may also wish to look just at patients who fit the end of life/palliative criteria as identified in activity 1.1. You may also wish to search by a particular provider. Instructions on how to do this can be found at* Identify patients seen by a particular provider or group of providers

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Reflection comments for **Activity 5.1:** Does anything surprise you? Is this what you expected?

Practice name: **Date:**
Team member:

Activity 5.2 – Understanding your practice's MBS claiming

The aim of this activity is to increase your understanding of the MBS item number claiming at your practice.

Description	Status	Action to be taken
After completing activity 5.1 are there any unexpected results with the number of MBS items claimed at your practice?	☐ Yes: **see actions to be taken** ☐ No: continue with activity	Please explain: (for e.g. low number of health assessments completed, higher rate of GPMP than expected) How will this information be communicated to the practice team?
Is your practice utilising MBS claims as you expected?	☐ Yes: continue with activity ☐ No: **see action to be taken**	Outline the differences – is it active population, age group differences, male/female populations? How will this information be communicated to the practice team?
After reviewing your patient MBS claiming, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken to help set you goals.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part- PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

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Reflection comments for **Activity 5.2:** Does anything surprise you? Is this what you expected?

Practice name: **Date:**
Team member:

Activity 6 - Marking Patients Deceased in your clinical software

Once a patient has passed away, it is important for a GP to review the patient file and to ensure that a staff member marks the patient as deceased in your clinical software package. This is to ensure accurate information is kept for each patient and reminder letters/contacts are not made with a deceased patient's family. Instructions for BEST PRACTICE and MedicalDirector on marking patients deceased.

GPs and Death Audit

The GP may wish to complete After Death Audits this helps to review the treatment, services and if the health needs of the patient were met.

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Activity 7 - Resources & Training

PROGRAM	DESCRIPTION
NPCC NATIONAL PALLIATIVE CARE COORDINATION PROGRAM	The National Palliative Care Coordination Program (NPCC) will help deliver a sustainable health system that is responsive to the increasing burden of chronic conditions, and the delivery of Australia's National Palliative Care Strategy by increasing access to palliative care (particularly for underserved populations) and improving collaboration and coordination of palliative care. It will support primary care physicians, including community-based GPs, nurse practitioners and treating specialists, in managing palliative care problems and in initiating specialist palliative care referral for more complex issues.
Advance Care Planning Australia BE OPEN | BE READY | BE HEARD	ACPA (Advance Care Planning Australia) is a national program, supported by funding from the Australian Government, for health professionals, care workers and the general public. It encourages people to consider their values, beliefs, and current and future health goals. The program offers a range of educational support about advance care planning, including online courses, webinars and other online learning resources (visit ACPA's 'learning' page), as well as face-to-face workshops. The program also offers a free national advisory service that provides personalised advice, resources and information on advance care planning, for both health care professionals and individuals. **Phone:** 1300 208 582 **Hours:** 9am–5pm, Monday to Friday **More information:** Visit Advance Care Planning Australia
The Advance Project®	The Advance Project is a national program funded by the Department of Health to support general practices to integrate advance care planning and palliative care with everyday clinical practice. The program offers a range of tools and types of educational support for GPs, practice managers and practice nurses, including: • a practical, evidence-based toolkit that includes screening and assessment tools • e-learning or online learning modules • post e-learning options such as one-on-one professional telephone mentoring and coaching support.

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	It's designed to support Australian general practices to integrate a team-based approach to initiating advance care planning and palliative care with everyday clinical practice. **More information**: Visit The Advance Project
PEPA Program of Experience in the Palliative Approach	PEPA (Program of Experience in the Palliative Approach) is an education and training program funded by the Department of Health. It aims to build the capacity of health professionals to deliver a palliative approach. The program offers free education and training support through placements, workshops, and online learning. It also offers financial support for health professionals to participate in a clinical placement of up to three days with a local palliative care specialist service. **More information:** PEPA
CARESEARCH palliative care knowledge network	CareSearch is a national program funded by the Department of Health to provide online access to evidence and evidence-based guidance on palliative care. The GP Hub reflects the reality of palliative care for GPs. There is prescribing and symptom management advice as well as information and resources relating to psychosocial complexity, clinical decision-making for the deteriorating patient, emergencies, and planning for a home death. In early 2024 CareSearch will be launcing an app- CareSearchgp, a resource designed to empower GPs in delivering quality palliative care. In addition, CareSearch offers educational support for different disciplines, including: • postgraduate formal qualification programs in palliative care, in partnership with universities (for health professionals) • conferences, short courses, workshops, e-learning, and 'my learning' modules, which demonstrate how to find relevant evidence (for health professionals) • courses and training for care workers, carers, volunteers and the community • resources for managers and educators about workforce development.

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	More information: Visit CareSearch GPs and Palliative Care
palliAGED PALLIATIVE CARE AGED CARE EVIDENCE	palliAGED is funded by the Department of Health and managed by CareSearch. It provides palliative care evidence and practice resources for aged care. It offers tools and educational supports for health professionals including: • apps for GPs and nurses that provide easy, convenient access to information about end-of-life care • an online learning and a course selection tool • postgraduate formal qualification programs. **More information:** Visit palliAGED's practice centre webpage
ELDAC End of Life Directions for Aged Care	ELDAC (End of Life Directions for Aged Care) is a national specialist palliative care and advance care planning advisory service, funded by the Department of Health. The service comprises a comprehensive website and a telephone advisory service. ELDAC has several toolkits to assist care providers who work in aged care to participate in palliative care and advance care planning: • the Home Care Toolkit • the Primary Care Toolkit • the Residential Aged Care Toolkit • the Legal Toolkit • the Working Together Toolkit. Each toolkit offers personal learning and online training, as well as information about conferences, short courses, workshops, and clinical experiences. The ELDAC website also has a list of the common clinical tools used for recognising end-of-life patients, and for assessing palliative care needs. **More information**: Access the ELDAC toolkits
PCOC palliative care outcomes collaboration	PCOC (Palliative Care Outcomes Collaboration) is a national palliative care project funded by the Department of Health. Its role is to assist care providers to embed standardised clinical assessment tools for palliative care into routine practice.

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	PCOC also helps to capture clinically meaningful information, such as patients' disease trajectories, to measure and benchmark patient outcomes for palliative care. The service provides educational support about the PCOC assessment tools, implementing PCOC and patient outcome reports, including how to use data to make improvements. Educational support for clinicians and managers includes: • online essential courses • workshops • a self-directed education package. PCOC also provides tools and resources including: • a clinical assessment and response form • a quality and change toolkit • data collection tools and guidance • data reports for patient outcome and benchmarking. **More information:** visit PCOC
caring @home Symptom management resources for palliative patients	Caring@home supports people to be cared for and to die at home, if that is their choice. The service is funded by the Department of Health. It supports health professionals to train carers to give subcutaneous medicines safely to their family member, to help manage 'breakthrough' symptoms to improve symptom control. Training is via online education modules, webinars and podcasts. **More information:** Visit Caring@home Health Professionals webpage
Talking End of Life ...with people with intellectual disability	Funded by the Department of Health, TEL (Talking End of Life) provides disability support professionals or workers with resources to teach people with intellectual disability about end-of-life. Resources include 12 online learning modules with case studies, videos, resources and links. **More information:** visit Talking End of Life with people with intellectual disability

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ELLC End of Life Law for Clinicians	End of Life Law for Clinicians (ELLC) is a free training program funded by the Department of Health for medical practitioners, medical students, nurses and allied health professionals about the law relating to end of life decision-making. It aims to improve clinicians' knowledge and awareness of the law at end of life and support their delivery of quality end of life and palliative care. The ELLC training program comprises 13 free online training modules on end of life law, and training workshops delivered nationally. The ELLC online training modules contain interactive exercises, legal cases, clinical case studies, vignettes, self-assessment quizzes, and further readings to promote reflective learning. The modules are self-paced and can be completed on any device. **More information**: Visit ELLC
Quality of Care Collaborative Australia Delivering Education in Paediatric Palliative Care	QuoCCA (Quality of Care Collaborative Australia) is a program funded by the Department of Health to deliver paediatric palliative care education to health professionals who may care for children and young people with life-limiting conditions, or with end-of-life care needs. The program offers a range of support including: • education sessions and workshops • 'pop-up' visits by a team of specialist paediatric palliative care teams and educators for education for the child, family and local health team • an online learning module **More information:** visit QuoCCA
end-of-life ESSENTIALS®	End-of-Life Essentials provides online learning opportunities and practice resources for doctors, nurses and allied health professionals. Funded by the Department of Health, it aims to improve the quality and safety of end-of-life care in hospitals. The program offers: • free online education (see link) • 'My Toolkit', which brings together tools, resources, promotional materials, and evidence to assist change in practice. **More information**: Visit End-of-Life Essentials
AGENCY FOR CLINICAL INNOVATION	This library of educational videos on palliative care has been provided by respected experts and specialists in their fields. The videos aim to better equip health professionals and other partners gain confidence

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	and specialised knowledge in the delivery of appropriate palliative care to people in need. The ACI acknowledges the original consortium partners who commissioned these videos including HammondCare, Sacred Heart Health Service, Calvary Health Care Kogarah and the NSW Ministry of Health in 2014. These videos were reviewed in 2022 to ensure they remain relevant and clinically appropriate. Please note staff may have moved to new roles and organisations since this content was filmed. The presenters positions are current as at July 2022. More information: visit Agency for Clinical Innovation- Palliative Care Video Library
Palliative Care Education and Training Collaborative Learning Management System	A GP online learning module accessed through PEPA's free learning management system. Modules cover: • principles of palliative care • communicating with people with life-limiting illnesses • advance care planning • assessing and managing symptoms • assessing and managing pain • awareness of self-care **More information:** visit Palliative Care Education & Training Collaborative
Paediatric Palliative care	Paediatric Palliative Care has been co-designed with health care professionals, support organisations, and families to provide quality information and resources about paediatric palliative care as well as a National Service Directory in one easily accessible location. The website provides specific paediatric palliative care information, resources, educational and self-care tips for health professionals. Resources include: • A practical guide to palliative care in paediatrics • An overview to family meetings and difficult conversations • Symptom management plan for health professionals • Transferring child requiring palliative care at home for health professionals **More information**: Visit I am a Health Professional - Paediatric Palliative Care

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	LGBTIQ+ Health Australia has launched all four of their Palliative Care modules. The FREE eLearning aims to increase healthcare providers' confidence in providing LGBTIQ+ inclusive palliative care. The eLearning topics are explored across four 1-hour modules: Module 1: Introduction to LGBTIQ+ communities Module 2: Barriers to providing and receiving palliative care Module 3: Enablers for LGBTIQ+ people in palliative care Module 4: Having end-of-life planning conversations **More information**: visit Palliative Care - LGBTIQ+ Health Australia
	Palliative Care ECHO is a series of interactive virtual (via Zoom™) mentoring sessions that addresses a range of palliative care topics chosen by health professionals in the primary care sector. The monthly sessions for health professionals, aim to increase palliative care knowledge, skills and confidence in the primary healthcare sector across the country. Each 1-hour Palliative Care ECHO session is facilitated to be a safe and supportive online environment and consists of: • A 10-minute presentation by a Multidisciplinary Palliative Care Specialist team (teams come from a range of states and territories) • A deidentified case presented by a primary care professional, allowing for specialist input and discussion among peers • Lots of opportunities for Q&A and discussion **More information**: visit Palliative Care ECHO – Project ECHO
	Gwandalan have developed a series of eLearning modules, resources, and webinars to support frontline staff deliver culturally responsive palliative care to Aboriginal and Torres Strait Islander Communities. **More information:** visit Gwandalan - Supporting Palliative Care for Aboriginal and Torres Strait Islander Communities

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Links to other QI toolkits

Central and Eastern Syndey PHN have a suite of QI toolkits available for general practice. The toolkits are designed to:

- Enhance patient care and outcomes
- Assist practices fulfill their quality improvement requirements under PIP QI
- Allow you to choose the area of work you would like to focus on and enhance

The full suite of toolkits are available on Central and Eastern Syndey PHN's website.

Registering completion or submitting feedback

Following completion of the QI toolkit and/or to submit feedback please submit the Practice QI Feedback Form.

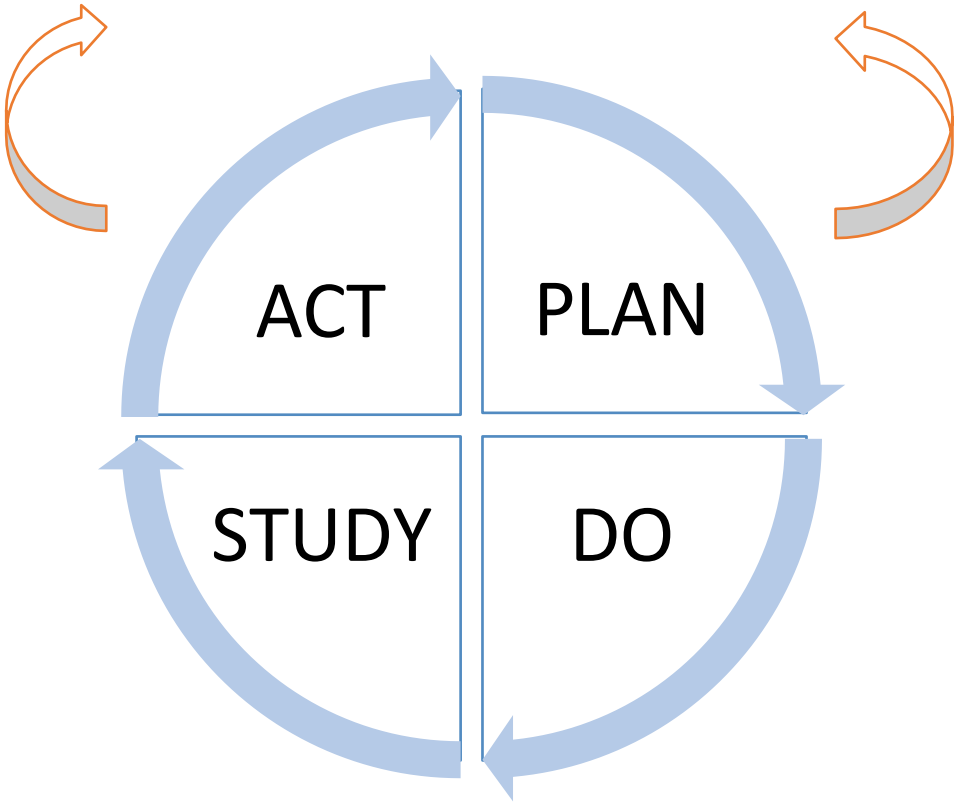
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Model for improvement diagram

What are we trying to accomplish?

How will we know if a change is an improvement?

What changes can we make that will result in improvement?



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Quality Improvement Activities using The Model for Improvement and PDSA

Name of Practice: Date:

Name of QIA:

Quality Improvement Team	
Names	**Roles/Responsibilities**

GOAL (Simple, Measurable, Achievable, Realistic, Timely) What are we trying to accomplish and when?	Identify active patients with dementia who do not have a GP Management Plan recorded in the past 12 months
MEASURES What data will we use to track our improvement? Eg POLAR	Collect information on Polar on the number of patients with dementia who have had or have not had a current GP Management Plan. Data to be collected over a 2-week period. Create list of patients who may benefit from having a GP Management Plan.
INITIAL BENCHMARK What is our current data saying?	Predicted 50% of patients with dementia have had a recent GP Management Plan
IDEAS What changes will we make that will lead to an improvement? NB: These ideas are not practice specific and are designed to give you some general ideas. The QI Team should develop these ideas together. To assist with clinical decision making, consider using HealthPathways, see: HealthPathways Sydney: https://sydney.communityhealthpathways.org/ Username: connected P/w: healthcare. HealthPathways South East Sydney: https://sesydney.healthpathwayscommunity.org Username: sesydney P/w: healthcare	1. Identify who in the team will collect the data. 2. Allocate protected time to collect the data. 3. Review if data meets initial benchmark. 4. Allocate GPs list of eligible patients- consider contacting these patients to book in an appointment for a GP Management Plan or ensure they are booked in for a longer appointment at their next scheduled visit.

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PLAN How will we do it?				DO Did we do it? Unexpected problems?	STUDY Review/reflect on results Lessons learnt What did/didnt't work well?	ACT Next steps? Review or extend activity?
	What	Who	When			
1						
2						
3						
4						
5						
6						

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