The ADVANCE program: Equipping and training practice nurses in comprehensive end of life care planning.

Prof Geoff Mitchell,
SPICT conference – University of Edinburgh
Friday, 2nd February, 2018
Advance Project Team

Led by HammondCare (http://www.hammond.com.au/) in collaboration with various Universities and health organisations:

- Project Director and Chair of the Advisory Group: A/Prof Josephine Clayton
- Project Coordinator: Jennifer Gavin, HammondCare
- Palliative Care Nurse Educator/Mentor: Jolan Stokes
- Post doctoral evaluation officer: Dr Srivalli Nagarajan, USyd

National Advisory Group Members:
- A/Prof Joel Rhee, HammondCare
- A/Prof Jennifer Tierman, CareSearch
- Prof Jane Phillips, UTS Sydney
- Prof Geoffrey Mitchell, UoQ
- Prof Elizabeth Halcomb, Uni Wollongong
- Dr Karen Detering, ACP Department, Austin
- A/Prof Rachael Morton, USyd
- Prof Tim Shaw, USyd
- Prof Elizabeth Reymond, Metro South, Brisbane

International Advisory Group Members:
- Prof Scott Murray & Dr Kirsty Boyd, University of Edinburgh
- Dr Felicity Murtagh, Cecily Saunders Institute, Kings College, London
- Prof Jane Seymour, University of Sheffield

Evaluation consultant: A/Prof Virginia Lewis, La Trobe University
Health economics evaluation officer: Ann Livingstone, USyd
Online learning module consultant: Dr Karen Cooper
Background

• One of the biggest barriers to providing palliative care (PC) and implementing advance care planning (ACP) in primary care settings is general practitioner (GP)’s time.

• Existing resources target training of GPs, however there are ongoing barriers to provision of PC and ACP in primary care.

• Nurses working in general practice are currently under-utilised in ACP/PC assessments
General practices – privately owned, fee for service primary care.

Patients not registered, free to use one or more practices.

Medicare – National universal health insurance – underwrites cast of attending GPs and other medical and specialist fees.

Multiple funding programs – consultation and procedural fee underwriting, Health checks, Health care planning, Mental health care planning, Targeted funding support funding (eg immunization)
Health checks

Target groups – over 75 (over 55 if Aboriginal/Torres Strait Islanders)

Consider issues not normally considered – eg isolation, incontinence, diet, as well as usual medical issues.

Interview process shared between practice nurses and GPs

Natural place to consider end of life planning.
About Advance

• Toolkit and multi-component training resource to enable general practice nurses to undertake screening of patients:

  • to promote awareness of ACP among older people and those with chronic/complex disease;

  • to identify general practice patients who may be at risk of deteriorating and dying, and in these patients:
    • assess their symptoms, important questions and concerns,
    • assess their caregiver’s needs and concerns,
    • identify those who might most benefit from referral to specialist PC services.
Aims of Advance

• To facilitate:
  • earlier consideration and uptake of ACP;
  • more efficient use of GP/GPN time in provision of PC/ACP;
  • more appropriate and timely referrals to specialist PC services, if required.

• To increase GPN’s confidence and comfort levels in initiating conversations with patients and their carers about ACP and screening for supportive care needs.
Specific activities


- **Workshops** to consolidate learning in each capital city (scholarships to enable rural/remote to attend), with availability of mentoring from PC nurse.

- A **train the trainer program** to enable sustainability of the program.

- **Nurses reimbursed to complete** the assessments to further consolidate their learning and encourage/inform ongoing implementation.
First phase:
GPN & GP identify 2 groups of patients, those who would benefit from:
1. ACP screening only
2. Full supportive care needs assessment including ACP screening

Second phase:
Tools used by the GPN to assess the patient’s and/or carer’s needs.

Third phase:
Patient’s/carer’s needs assessments are evaluated by the GPN/GP, and any additional support requirements are considered.
**First phase:**
GPN and the GP identify 2 sub-groups of patients, those who would benefit from:

1. ACP screening interview only

2. Full supportive care needs assessment including ACP screening interview
Where does SPICT fit in?

Initial screen of patients undergoing assessment is Surprise Question.

If Surprise Question answer:

“No” (I would not be surprised)
Nurse/GP discussion re assessment results.
Second phase: Tools are used by the GPN to assess the patient’s and/or carer’s needs.

Third phase: Results from assessments are evaluated by the GPN/GP, and requirements for additional support are considered (including specialist PC).
Advance Care Planning Screening Interview

[Image of a questionnaire with sections for patient information, screening questions, and follow-up notes. The questionnaire includes fields for patient name, date, and various Yes/No/NA options for different scenarios related to advance care planning.]
Outcome - Introducing the full supportive care assessment
## Barriers and strategies to implementation

Examples identified so far from workshops, mentoring and qualitative interviews

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace (e.g. resistance to change, getting GP/practice manager on board)</td>
<td>Complementary training for whole GP practice</td>
</tr>
<tr>
<td>Funding time spent by GPN</td>
<td>Use existing health assessments for ACP screening interview. Patients complete some tools in own time after introduced by nurse, followed by long consultation with GP to assess the identified needs</td>
</tr>
<tr>
<td>Tools paper based, some practices completely paperless</td>
<td>Fillable pdf, consider development of prompts in practice software</td>
</tr>
<tr>
<td>Not knowing what local support services are available and how to access them</td>
<td>Link with or develop local referral pathways (e.g. Health Pathways)</td>
</tr>
</tbody>
</table>
Key achievements over last 12 months

• Workshop delivery
  • 27 workshops including every state/territory
  • 406 participants including 347 GPNs (target was 250 GPNs)
  • 177 rural/regional participants
Advance online module participants

658 registered participants
202 completed all components
An excellent workshop, with great presenters and very relevant content. Very useful tools and I look forward to taking them back to my practice.

The tools allowed for focusing the patients' needs according to urgency and also were a vehicle or prompt for them to verbalise what they may have been feeling but for one reason or another were not voicing.

I believe because the nurse plays a large part in completing with the patient the assessment tools, the doctors would appreciate the summarized forms as they prioritize the patients' needs and help with time management.

Getting excited to implement ACP into my practice.

Loved the videos - very easy to understand. They were very "real scenarios". Great to see the tools in action.

This will be very beneficial to patients in my clinic and will help identify issues and start communication and planning for patients’ future care.
Online training feedback

• “I already initiate the discussion with all my patients who have chronic diseases. This program provides the tools that I can now use to do my job better, also will make it easier to have documentation to then show the GP”

• “Complements my work in the GP clinic. Will increase my opportunities and ability to discuss the patients and their carers needs and support required.”
Future Directions

• Whole of general practice approach – Advance training for GPs, GP registrars and practice managers

• Identify other priority target groups of clinicians and adapt Advance training/resources to meet their needs, for example:
  • Other nurses, physicians and allied health staff in primary, chronic/complex care, or community aged care settings
  • Clinicians who provide care for patients with specific chronic illnesses (e.g. advanced progressive kidney, lung, neurological or heart disease)

• Support champions networks/services to deliver face-to-face training and support implementation locally

• Collect in depth data from a subset of clinical sites to inform ongoing implementation