

The Economic Benefits of Palliative Care and End-of-Life Care in Residential Aged Care



KEY FINDINGS

- Identifying the need for palliative care in residential aged care can be difficult as residents often have multiple morbidities with differing illness trajectories, varying levels of cognitive decline, complex symptom management, and time to death is often unpredictable.^{6,13-15}
- Staffing levels in residential care tend to be low, there are competing demands on nursing time, and medical care to residents is largely provided by GPs, is often unavailable and is very time limited.^{6,13} This creates challenges for the provision of high quality palliative and end-of-life care.^{6,7,13}
- The economic evidence shows an investment in palliative care in residential aged care that better meets the needs of residents produces a significant economic return through the reduced use and costs of ambulance services, ED visits and admissions to hospital.

WHAT IS PALLIATIVE CARE AND END-OF-LIFE CARE?

The WHO defines Palliative Care as “an approach that improves the quality of life of consumers and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”.¹ Palliative care is for people of any age who have a serious illness that cannot be cured. Dying is a normal process with palliative care offering a support system to help people to live their life as fully and as comfortably as possible until death and to help families cope during this illness and in their bereavement. People are approaching the ‘end of life’ when they are likely to die within the next 12-months.²

PALLIATIVE CARE IN RESIDENTIAL AGED CARE

Residential aged care provides a range of services including accommodation, nursing, other personal care and supervision. In 2014-15, there were 231,465 Australians living permanently in residential aged care, 64,000 of whom entered residential care during the year.³ Many residents have progressive chronic life-limiting illnesses. In 2014-15, some 55,605 individuals died in residential aged care. This means that 35% of all deaths in Australia occurred in residential aged care.⁴ Deaths in residential aged care account for around 46% of the costs of death in Australia.⁵ The estimated total cost of residential care in the last year of life of residents who died in residential aged care was about \$2.3 billion (2013-14 dollars).⁵ Residential aged care, however, has not been recognised as a site of palliative and end-of-life care, with developments in palliative care only occurring in this setting in recent years.^{6,7}

The provision and administration of palliative care in residential aged care is often difficult because a large proportion of residents can have complex care needs and a residents communication and cognitive impairment can be impacted.³ Access to appropriate palliative care services for residents is also often very limited. Under the *Aged Care Act 1997*, it is the approved residential aged care provider who is responsible for providing access to a qualified practitioner from a palliative care team and establishing the palliative care program.⁴ In 2014-15, only 4% of permanent residents i.e. 9,144 individuals had received a formal appraisal indicating that they required palliative care.⁴ The majority of residents who received palliative care lived in Australia’s major cities (5,346 residents) or inner regional areas (2,942 residents). However, the proportion of permanent aged care residents receiving palliative care, although still low, was highest in inner regional areas e.g. Tamworth, Ballarat, Rockhampton (5.7%) followed by outer regional areas e.g. Broken Hill, Roma, Mount Gambier (4.4%).

Around 73% of permanent aged care residents in 2014-15 who were receiving palliative care died in 2014-15, compared with 22% of the other residents.⁴ With respect to length of stay, about one in five residents requiring palliative care die within a month of being admitted to residential aged care, 40% within 3 months and 55% within a year.⁴ For the other residents, about 5% die within a month, 10-15% within 3 months and 30-35% within 12 months.⁴ Thus, residential aged care mortality is high but the data suggest there is significant unmet need for both end-of-life care and palliative care over longer term.^{6,7}

ECONOMIC BENEFITS OF PALLIATIVE CARE IN RESIDENTIAL AGED CARE

Increased provision of palliative care in residential aged care has been shown to reduce hospital admissions of residents and to provide more symptom control, pain relief and comfort for both residents and their families. Over 50% of residents have dementia but residents with dementia receive palliative care infrequently.^{3,4} A Western Australian study examined Emergency Department (ED) use by people in their last year of life and who had dementia with two cohorts living in residential aged care.⁸ In the first 130 days of the last year of life, residents with dementia who received regular care visited the ED 1.4 times more often than those receiving palliative care. In the last month of life, residents with dementia receiving regular care visited EDs 3.1 times more frequently than the dementia cohort who were receiving palliative care at that time.

A study undertaken in Sydney compared 21 residential aged care services that had introduced advance care plans (ACPs) with 13 control services.⁹ Over a 3 year follow-up period, a significant difference occurred in the number of emergency calls to the ambulance service

from the services implementing ACPs who recorded a 1% reduction in calls compared with a 21% increase in the services without ACPs. The relative risk of residents of the services using the ACPs being admitted to hospital compared with the residents of the control nursing homes was 0.89. After 3 years, the rate of total inpatient hospital days was more than double for residents from the control service not implementing ACPs.

In a more recent study, ACPs were introduced into three Irish nursing homes.¹⁰ The results showed that after implementation of end-of-life care per the ACP, there was a significant decrease in the rate of hospitalisation of residents, inpatient hospital days and the percentage of residents dying in hospital also decreased. An economic analysis indicated that the reduced hospitalisation and ambulance transfers resulted in large cost-savings in the order of \$AUD 27.1 million per annum if the findings were

extrapolated nationwide. These results are supported by the findings of a systematic review of the literature on the effects of ACP interventions for nursing home residents - ACP decreased hospitalisation rates by 9%-26%, there were significant increases in the number of residents dying in residential aged care, and a decrease in overall health costs.¹¹

A recent Australian study¹² also showed that a proactive model of specialist palliative care within residential aged care services was associated with substantial reductions in the length of hospital stays (45%) and a lower incidence of death in the acute setting. While rates of hospitalisation were unchanged on average, the reduction in length of stay of 3.2 days resulted in a 67% decrease in the overall number of admitted days. The cost-savings associated with the reduction in hospital bed days equated to an average cost savings of \$2,955 per patient.

TED'S STORY

Ted was an 81 year old man with Lewy body dementia and associated Parkinsonism causing tremors and stiffness. Ted was living in residential aged care and did not have an advance care plan (ACP). The residential care staff requested assessment by the palliative care team when Ted's condition started to deteriorate, and they meet with his wife Ruth who held his Enduring Power of Attorney.

Ted had an ACP developed which stated that he wanted to avoid hospital. It was discovered that the care provider had a policy requiring hospitalisation of any resident taking blood thinning medication and who has a fall. The palliative care team, in liaison with Ruth, ceased the medication and instructed that Ted was only to be taken to hospital in specific circumstances so as to observe his wishes. Ted's condition deteriorated and he developed aspiration pneumonia, experienced vivid visual hallucinations, stopped eating and became dehydrated. Without the palliative care team, Ted would have been sent to hospital.

With Lewy body dementia, knowledge of specialist medication was required for Ted's care. The specialist palliative care team, with the consent of his wife, agreed not to administer antibiotics to treat the pneumonia, but rather to provide carefully selected medications for temperature control, pain relief and to reduce delirium. Some of these medications are not available under the Pharmaceutical Benefits Schedule (PBS) and therefore not readily available to residential aged care staff.

With the adjustment of his medications Ted was restful and died in residential aged care after 10 days. Ruth was relieved that he was able to die comfortably and peacefully in this setting, which had become his home. The staff and Ted's GP were also grateful for the specialist and dedicated palliative care support.

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