Palliative Care Equipment Program (PCEP) – Updates and Case studies

Queensland Government

Medical Aids Subsidy Scheme
23 October 2024

Session Structure

- PCEP Updates
- Streamlining PCEP Applications
- VAD & PCEP
- Prognostication

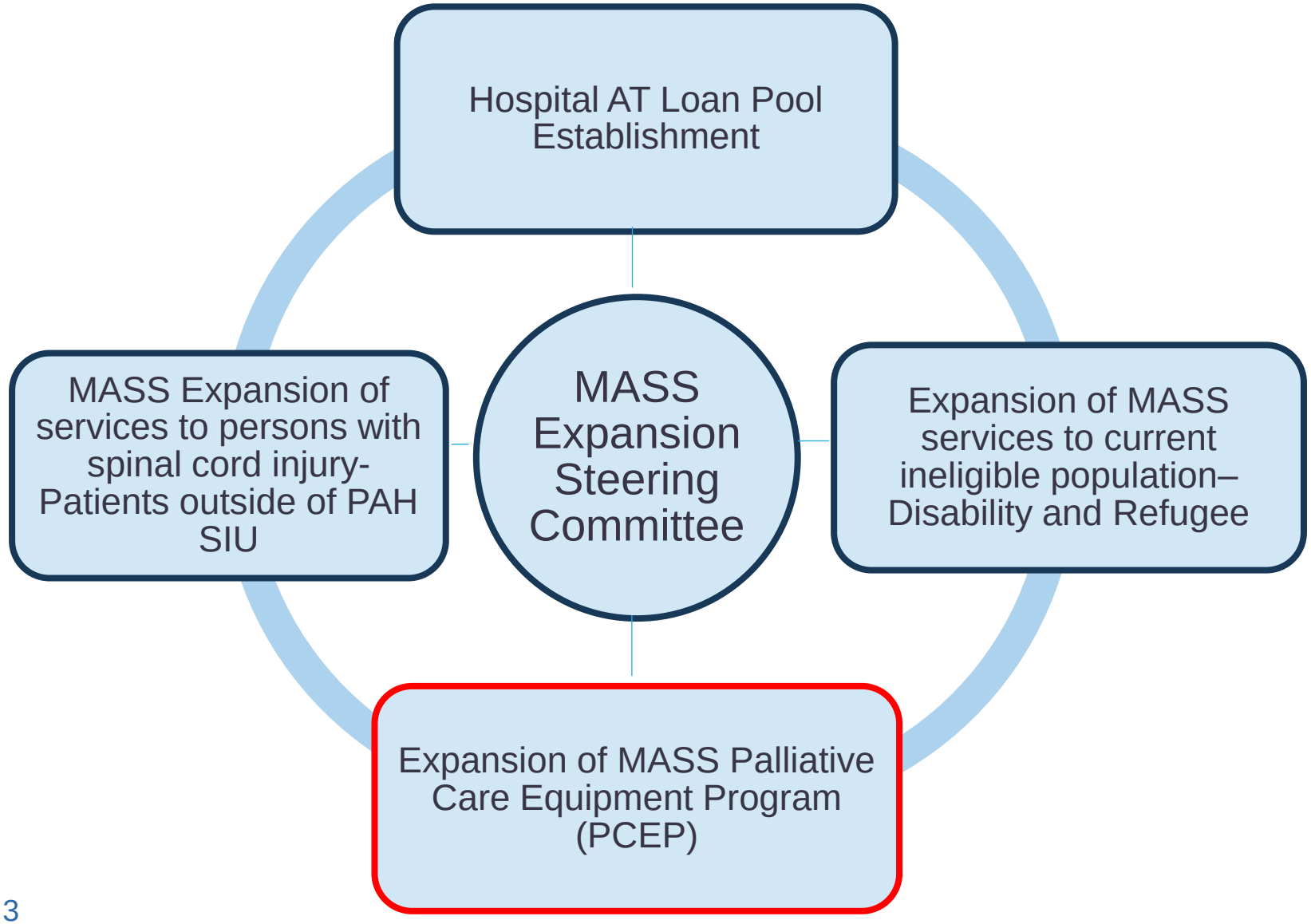
Case Studies

Hayley Coulson
Qld Children's Hospital

Julia Douglas & James Chirgwin
The Wesley Hospital

Suzy Smith, Emily Mitchell & Ellen O'Connor
SPaRTa

MASS Expansion Project



- Megan Wood – Senior Project Officer
- 4 x Working Groups
- Report to MASS Expansion Steering Committee
- Statewide Consumer Engagement Focus Groups
- Pilot projects – for review
- Funding to be utilised by June 2025

PCEP Statistics 2023-24 FY

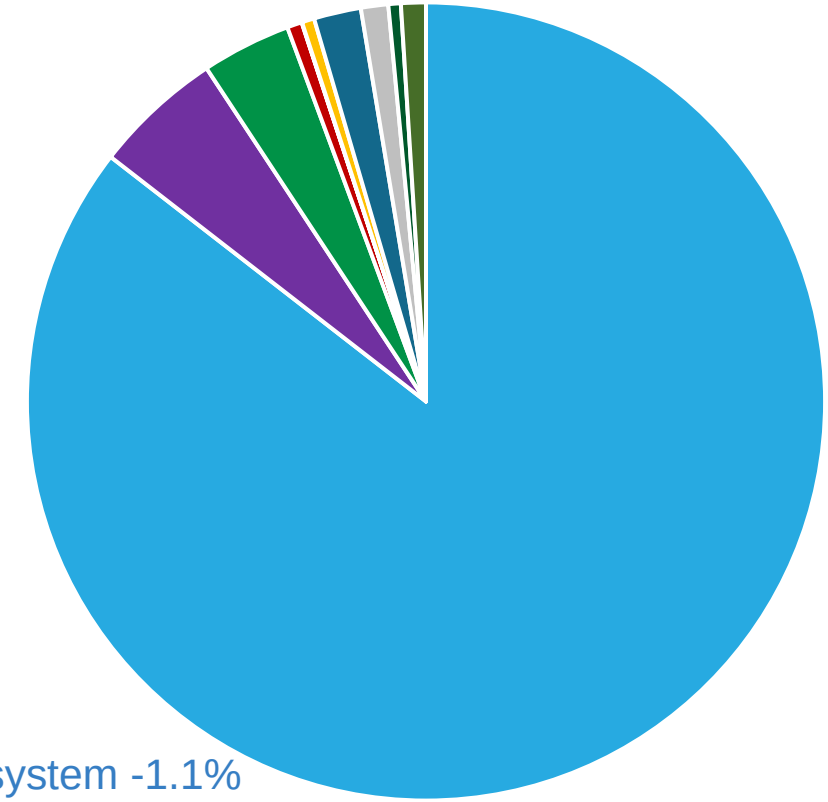
2,002 PCEP clients

1,462 PCEP clients deceased

10,819 AT items provided

Average days on PCEP – 108.84

PCEP Diagnosis Statistics -



- Cancer - 85%
- Lung disease - 5.2%
- Heart disease - 3.6%
- Liver disease 0.6%
- Degenerative Neuro -1.4%
- Extrapyramidal & MD - 0.5%
- Renal Failure -1.9%
- Systemic atrophies of nervous system -1.1%
- Organic mental disorders -0.5%
- Other -1%

1 April 2020 – 31 March 2022

Median Age – 72 years

Male – 2,084
Female – 1,738

PCEP Equipment Statistics -

1235 Pressure Redistribution Mattress	1135 Hospital Bed	1038 Over Bed Table	1033 Pressure Redistribution Cushions	848 Manual Wheelchair
664 Over Toilet Frames/Surround	552 Wheeled Walking Aid	572 Mobile Shower Commode	488 Electric Recliner Chair	373 Shower Chairs
283 Static Commode	252 Shower Stool	103 Patient Transfer Platform	98 Bath Transfer Bench	65 Mobile Floor Hoist

Streamlining your PCEP Application

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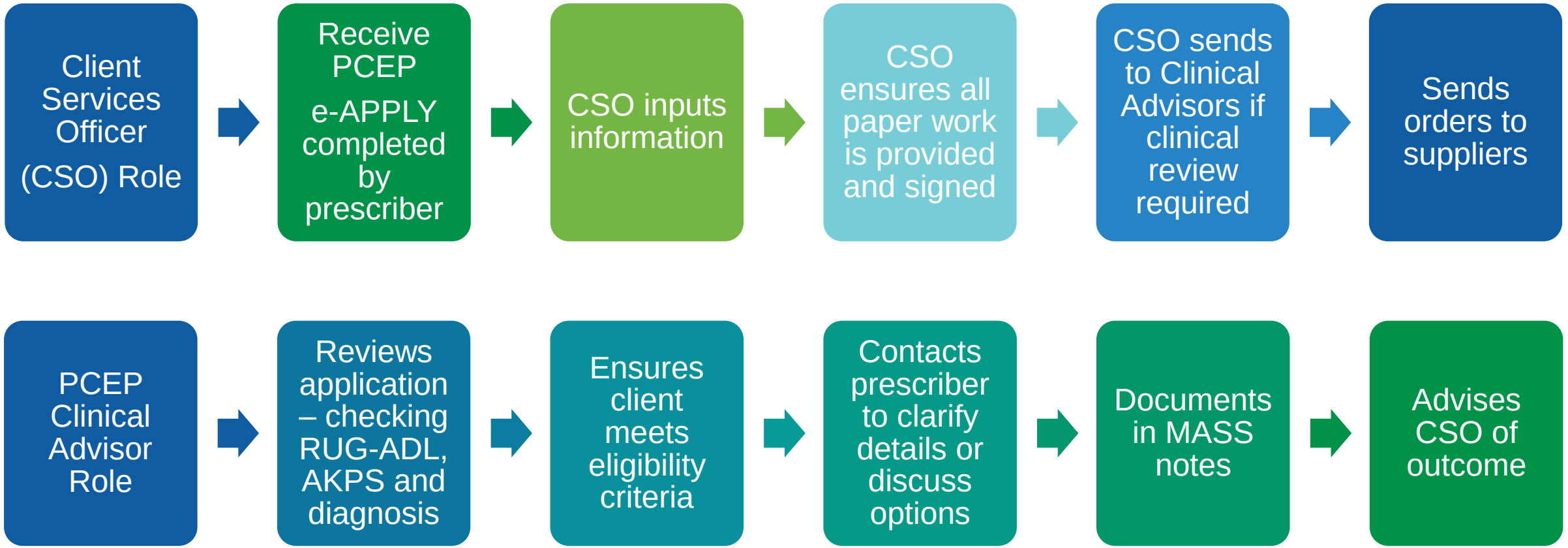
PCEP Process -



Application Reviews -

Guidelines for Palliative Care Equipment Program

- RUG-ADL or AKPS do not meet eligibility criteria for AT
- Clinical information is limited
- A single item of AT is requested
- Equipment is requested that may require additional AT e.g. prescription of regency chair and nil hoist
- You have requested something that is not available for hire e.g. 14 x 14-inch TIS manual wheelchair

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Clinical Support -

Simone Dullaway Renae Kelly

Application Tips - *Provide comprehensive clinical information*

Example:

	Limited Information	Comprehensive Information
Applicant's Primary Diagnosis	Degenerative Neurological	Degenerative Neurological
Subcategory	Motor Neurone Disease	Motor Neurone Disease
Further information on diagnosis or relevant co-morbidities:	Nil information provided	Client is in bed or recliner for 24/7 - apart from toileting/showering. 2 x care support workers. Fully PEG fed. Hoist transfer. Has equipment from MNDAQ - bed, repose mattress and contur, hoist with power pivot frame, ramps and upright shower commode - which is no longer suitable. Needs TIS shower commode. ALS-FRS – 15/48

Application Tips - *Provide comprehensive clinical information*

Example:

	Limited Information	Comprehensive Information
Applicant's Primary Diagnosis	Oncology	Oncology
Subcategory	Lung cancer	Lung cancer
Further information on diagnosis or relevant co-morbidities:	Nil information provided	Metastatic SCLC with brain metastases. Osteoporosis with crush fractures to vertebrae. Recent fall with left pubic rami #. 5 m with hopper frame and 1 x assist. Fluctuating transfers needing 2 x assist with Sara Stedy. History of stage 2 pressure injury – sacrum. Incontinence x 2 Decreased cognition

Application Tips - *Provide comprehensive clinical information*

Example:

	Limited Information	Comprehensive information
Applicant's Primary Diagnosis	Medical Condition	Medical Condition
Subcategory	Other Medical Condition	Chronic Kidney Disease
Further information on diagnosis or relevant co-morbidities:	Nil information provided	ESRF - Client has SOBOE and lower limb swelling. Congestive heart failure. High risk of falls due to dizziness. Has ceased renal dialysis. Bone pain. Malnutrition. Nausea Estimated eGFR >15mL/min Would benefit from additional equipment, when ready to accept. Accepting Shower chair only.

Equipment Selection

Do I need to complete a script form for toileting and mobility aids?

- Usually no. Provide anthropometrics if non-standard size or paediatric/bariatric size. If needing wider than standard – please state e.g. Must be 500mm wide

Can I get a Sleep Positioning Cushion?

- Yes – but needs to be on SOA and available for hire. Only includes heel wedges and foam wedges.

Using PCEP Funding Wisely….

Before starting a PCEP application

- Talk to your team - before commencing PCEP funding.
- Liaise with the specialist if you are unsure about your client's prognosis.
- Consider if the timing is right for accessing PCEP?

Can I transition off PCEP before 6 months?

- Yes – If your client's health has improved/stablised, and longer approaching end of life.
- PCEP funding can be ceased and can recommence – using the balance of funding only.

Transitioning off PCEP

What happens if my client lives longer than 6 months?

- You will need to speak to PCEP ASAP. A Palliative Confirmation Extension Form will need to be completed and approved.
- Your client needs to be transitioned off PCEP if no longer eligible.

What do I do if my client is no longer considered palliative?

- Your client will need to be transitioned off PCEP if they are no longer palliative.
- Consider if your client:
  - is MASS eligible
  - can self-fund or hire some items, or
  - can have a home care package assist with purchase or hire.

Keeping Track of PCEP Clients

What happens when I handover a client to another service?

- Ensure the new service provider knows
  - that the client is on PCEP
  - the specific equipment that is on hire
  - the 6-month timeframe.

What do I do if I discharge a client whilst they are on PCEP?

- If the client is no longer palliative – they will need to transition off PCEP.
- If the client has decided they no longer wish to engage with your service – please let PCEP know.
- Managing PCEP clients who have no team in the community is very difficult.

Does Voluntary Assisted Dying (VAD) impact on PCEP eligibility?

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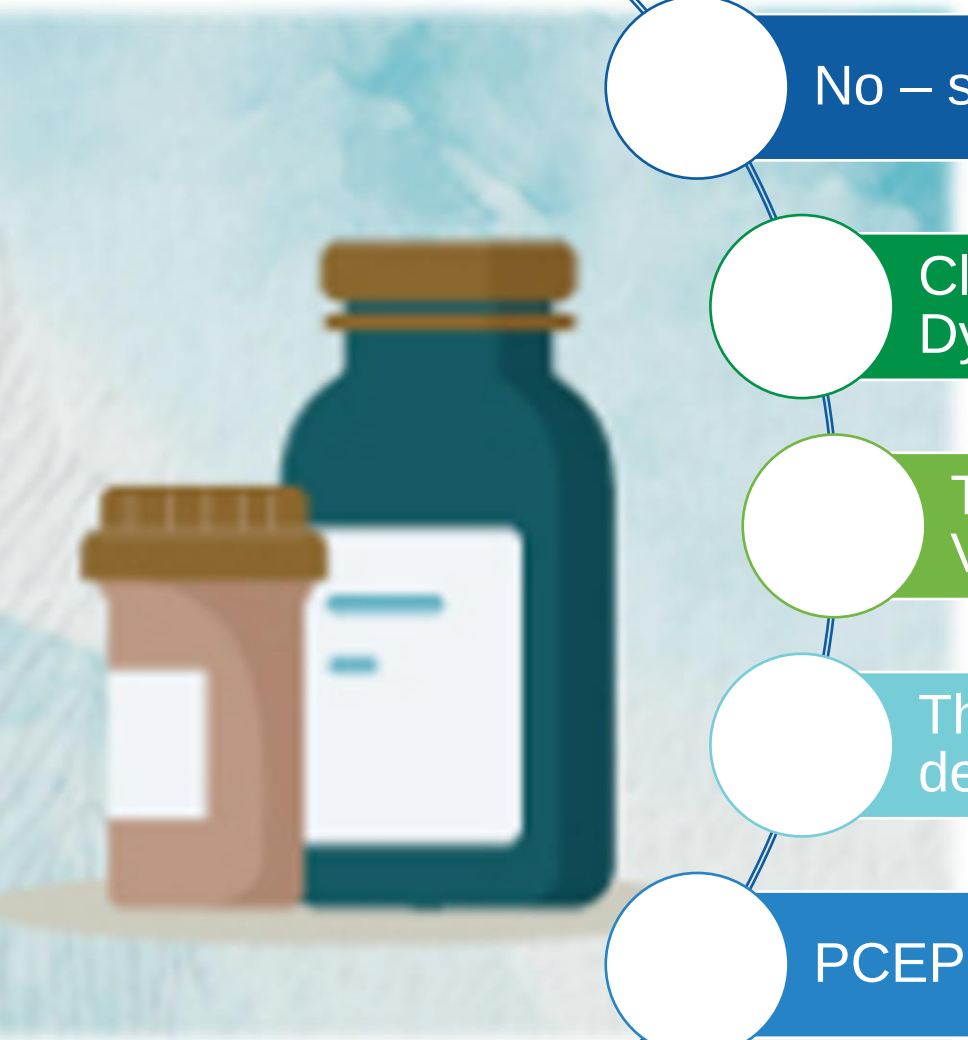
Does VAD impact on PCEP eligibility?



- No – still have 6 months of PCEP funding.
- Clients who meet the eligibility criteria for Voluntary Assisted Dying are still able to have equipment and support via PCEP.
- There is no guarantee that your client will proceed with the VAD process.
- The client's VAD eligibility may change if their cognitive status deteriorates.
- PCEP does not need to know that a client is considering VAD.

Prognostication

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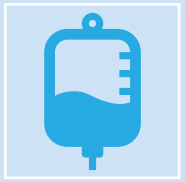
Prognostication -

“A prognosis is a prediction about the future trajectory of a person’s illness” (ref: www.caresearch.com.au 2024).

As prescribers we are predicting the person’s future equipment needs.



A lower AKPS score and higher RUG-ADL score correlates to a short number of days to death.

Prognostication -

A/Prof Graham Grove FRACP –
Medical Director – SPaRTa and Staff
Specialist Palliative Care, Gold Coast

Why is prognostication important?

- Helps patient and family decision making
- Aids planning for future needs
- Aid resource allocation

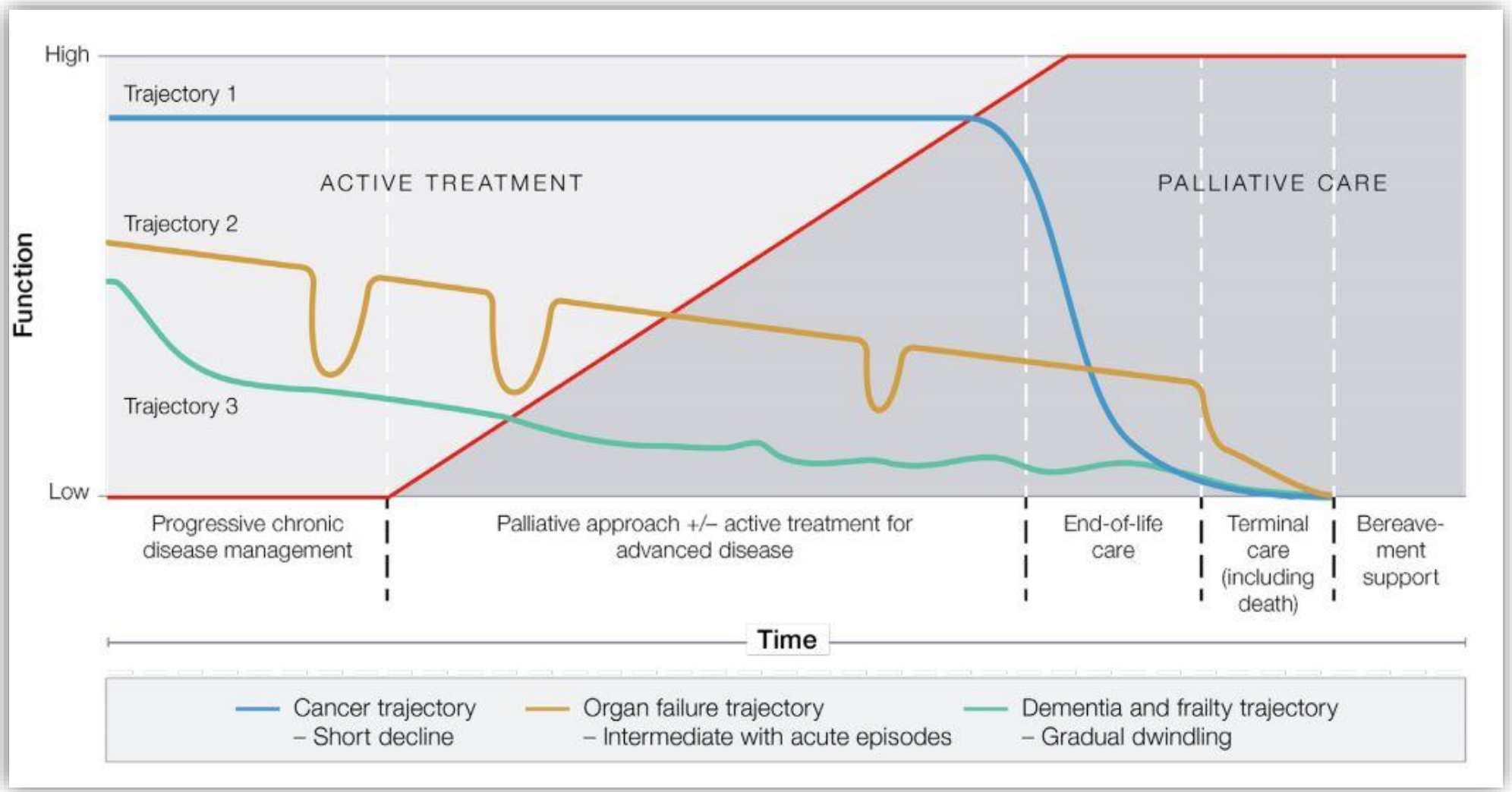
Prognostication accuracy:

- Cancer clients – more prognostic markers such as stage and spread of disease.
- Clients with chronic diseases, or frail/elderly are more difficult to prognosticate.

Recommendations:

- Ask what changes they are expecting, and potential time frames.
- Ask questions of your palliative care or medical specialist to help gauge your client's status.

Prognostication -



RACGP - Palliative and end-of-life care

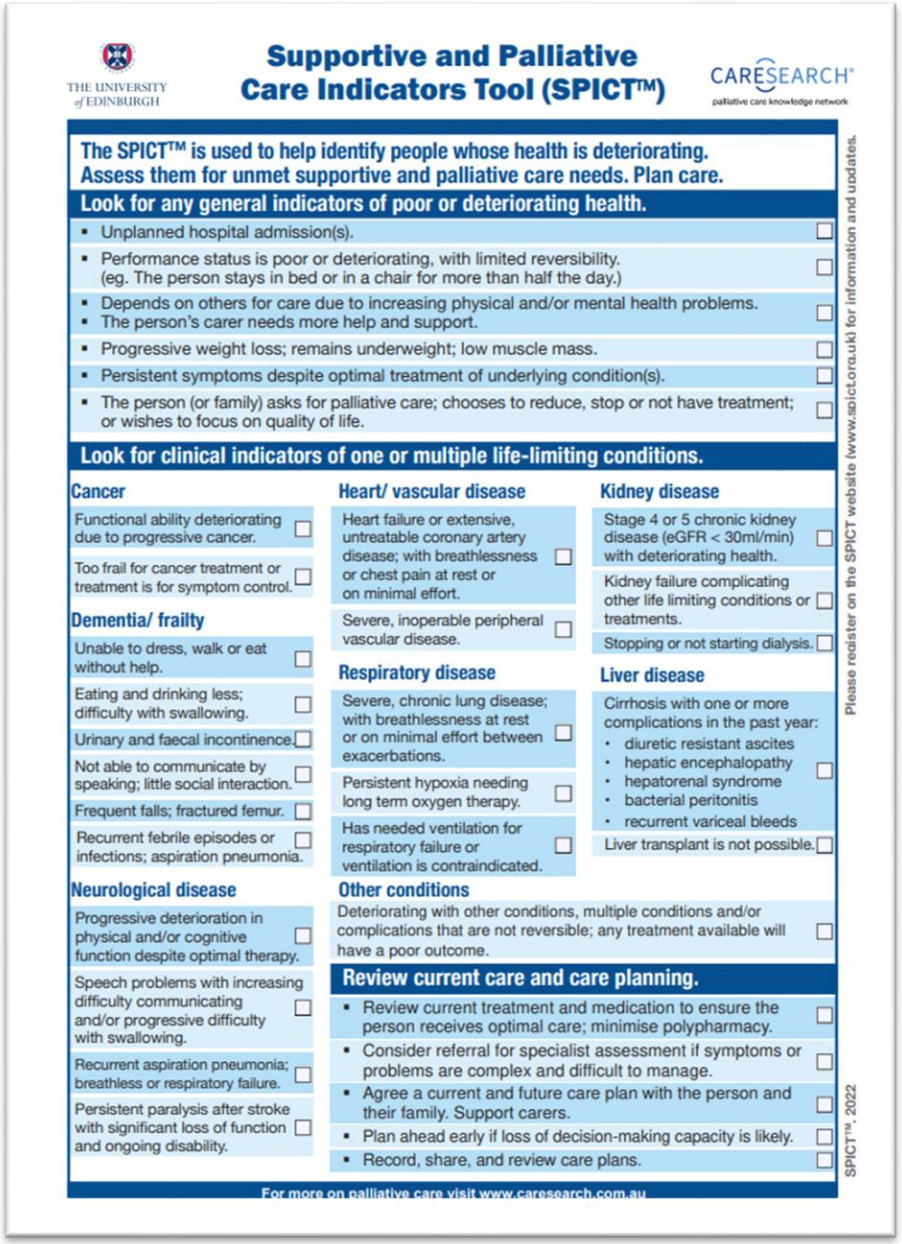
Prognostication -

PALLIATIVE PERFORMANCE SCALE (PPS)

%	Ambulation	Activity Level Evidence of Disease	Self-Care	Intake	Level of Consciousness	Estimated Median Survival in Days (a)	(b)	(c)
100	Full	Normal *No Disease*	Full	Normal	Full	N/A	N/A	108
90	Full	Normal *Some Disease*	Full	Normal	Full			
80	Full	Normal with Effort *Some Disease*	Full	Normal or Reduced	Full			
70	Reduced	Can't do normal job or work *Some Disease*	Full	As above	Full	145		
60	Reduced	Can't do hobbies or housework *Significant Disease*	Occasional Assistance Needed	As above	Full or Confusion	29	4	
50	Mainly sit/lie	Can't do any work *Extensive Disease*	Considerable Assistance Needed	As above	Full or Confusion	30	11	41
40	Mainly in Bed	As above	Mainly Assistance	As above	Full or Drowsy or Confusion	18	8	
30	Bed Bound	As above	Total Care	Reduced	As above	8	5	
20	Bed Bound	As above	As above	Minimal	As above	4	2	6
10	Bed Bound	As above	As above	Mouth Care Only	Drowsy or Coma	1	1	
0	Death	-	-	-	--			

(a) Survival post-admission to an inpatient palliative unit, all diagnoses (Virik 2002).
(b) Days until inpatient death following admission to an acute hospice unit, diagnoses not specified (Anderson 1996).
(c) Survival post admission to an inpatient palliative unit, cancer patients only (Morita 1999).

[The Palliative Performance Scale (PPS) | Palliative Care Network of Wisconsin (mypcnow.org)]



THE UNIVERSITY of EDINBURGH

Supportive and Palliative Care Indicators Tool (SPICT™)

CARESEARCH palliative care knowledge network

The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- Progressive weight loss; remains underweight; low muscle mass.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer
- Functional ability deteriorating due to progressive cancer.
- Too frail for cancer treatment or treatment is for symptom control.

Dementia/ frailty
- Unable to dress, walk or eat without help.
- Eating and drinking less; difficulty with swallowing.
- Urinary and faecal incontinence.
- Not able to communicate by speaking; little social interaction.
- Frequent falls; fractured femur.
- Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease
- Progressive deterioration in physical and/or cognitive function despite optimal therapy.
- Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.
- Recurrent aspiration pneumonia; breathless or respiratory failure.
- Persistent paralysis after stroke with significant loss of function and ongoing disability.

Heart/ vascular disease
- Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.
- Severe, inoperable peripheral vascular disease.

Respiratory disease
- Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.
- Persistent hypoxia needing long term oxygen therapy.
- Has needed ventilation for respiratory failure or ventilation is contraindicated.

Other conditions
- Deteriorating with other conditions, multiple conditions and/or complications that are not reversible; any treatment available will have a poor outcome.

Kidney disease
- Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.
- Kidney failure complicating other life limiting conditions or treatments.
- Stopping or not starting dialysis.

Liver disease
- Cirrhosis with one or more complications in the past year:
  - diuretic resistant ascites
  - hepatic encephalopathy
  - hepatorenal syndrome
  - bacterial peritonitis
  - recurrent variceal bleeds
- Liver transplant is not possible.

Review current care and care planning.
- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, share, and review care plans.

For more on palliative care visit www.caresearch.com.au

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™, 2022

[SPICT – Supportive and Palliative Care Indicators Tool]

Reflections from PCEP Prescribers

Queensland Government

Hayley Coulson

Physiotherapist

Area of Practice – Paediatrics: Oncology, Palliative Care and Haemophilia.

Queensland Children's Hospital

Queensland Government

Service Overview

- Paediatric Palliative Care:
- Queensland & Northern NSW
- Types:

➢Oncological Dx

➢Infants (antenatal)

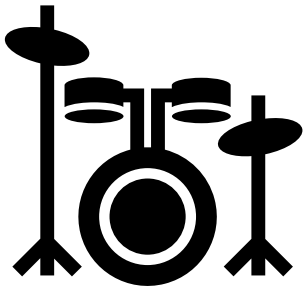
➢Neurological/ Neuro-degenerative (long term)

➢Neuromuscular

Case Study – Client information “Matt”

- Male
- 15-year-old
- Diffuse hemispheric glioma - July 2023

- QoL
- Teenager
- Strong religious faith
- Seeking out therapies overseas
- Mother nursing background



Case Study – Equipment Provided

- Provided a hospital MWC on diagnosis

- **PCEP equipment: 8 months after diagnosis**
  - Hi-lo bed and mattress
  - Standard commode
  - Recliner chair

- **Further deterioration and change**
  - Hoist and sling
  - TIS wheelchair
  - High-back TIS commode
  - Regency chair

- Diagnosis July 23→Equipment March 24 → RIP April 24

GOALS:

- Attend church (social)
- Comfort to enjoy music
- Play the drums
- Remain home for EoL

Case Study – AT prescription with palliative clients

- Key Learnings and Recommendations

- Families may take a while to come around to the higher acuity equipment.
- Do as much preparation (paperwork and measurements) prior.

- Do you have a "go to" piece of equipment?

- Go to “TIS wheelchair” or “Bingo Hoggi”.

- Describe any problem solving/strategies you used with AT to achieve the patient goal.

- Being adaptable and responsive to the clients changing needs and function.
- Think of other options to offer to families to include them in the decision-making process.

Julia Douglas,
Senior Occupational Therapist / Accredited Lymphoedema Therapist

James Chirgwin,
Senior Physiotherapist

Area of Practice – Palliative Care / Oncology

The Wesley Hospital, Auchenflower, BRISBANE

Queensland Government

Service Overview

- The Wesley Palliative Care Service is a multidisciplinary, holistic hospital-based service
- Focused on symptom control often starting through active treatment of disease such as chemotherapy and radiation.
- Team includes Palliative Medical Specialists / Registrars, Nurses, Counsellors, Complex Care Coordinators, Chaplains, Physiotherapist, Occupational Therapist, Speech Pathologist, Dietician, Pharmacist & Compassionate Companions
- The Wesley Palliative Care Ward (Ward 4A) has 17 beds, with up to 20 outliers across the hospital.

Case Study – Client information

- 67yo F with NSCLC and brain metastases
- Lived with husband, large supportive family local
- Initially, independently mobilising short distances with a 4WW, min assistance with PADLs, spending more than 50% of day in bed due to fatigue
- Deteriorated rapidly over the final week of her admission with worsening right sided power and co-ordination. Required 2 x assist Sara Stedy transfers and mod to full assist PADLs
- Function also limited by worsening concentration and cognition
- Increased carer stress / burden by functional decline – MDT family meetings undertaken due to uncertainty if patient to discharge home or remain at Wesley for end-of-life cares as per patient wishes

Case Study – Equipment Provided

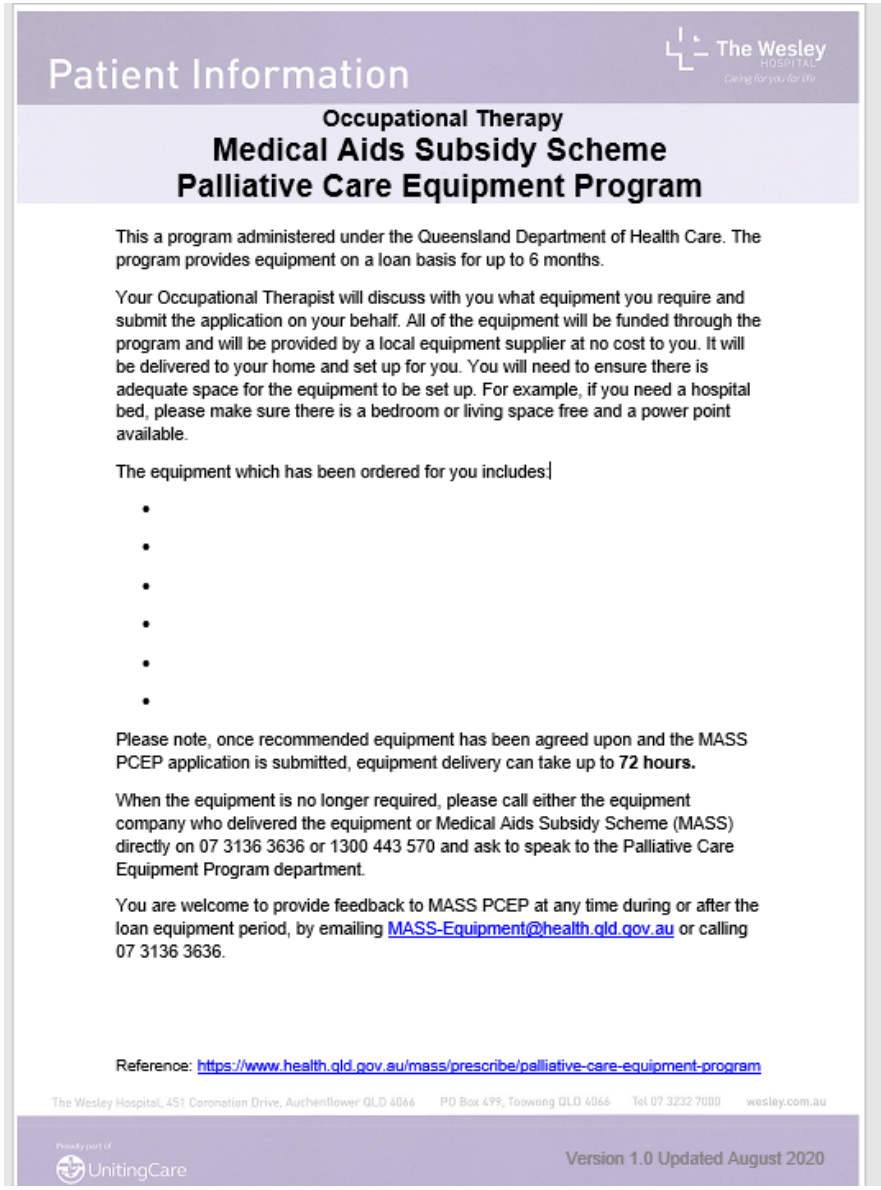
- **Initial MASS PCEP application** (5 days prior to estimated hospital discharge)
  - Hospital bed, alternating air pressure relief mattress, over bed table, shower chair, bedside commode, Hilite chair, 4WW, MWC with cushion
- **Subsequent MASS PCEP application** (2 days prior to hospital discharge)
  - Sara Stedy / Shifty, attendant propelled mobile shower commode with pan
  - Requested return of shower chair, bedside commode, 4WW

- Focus on carer training / support to ensure safe transfer / care methods and use of equipment for further functional regression upon return home for palliative care at home
- Clear handover to Community Palliative Care Services regarding patient's rapid functional deterioration and prescribed MASS PCEP equipment

Case Study – AT
prescription with palliative clients

Key Learnings & Recommendations

- MDT collaboration is key to ensure smooth and appropriate discharge planning for this population
- Balanced of being organized but adaptable to patient's dynamic presentation and wishes
- Clear communication with MASS PCEP clinical advisors regarding changes to prescribed equipment (especially with multiple applications)
- Clear education and expectation management for patient and family regarding MASS PCEP, carer training and linkage Community Palliative Care Services



Patient Information

The Wesley HOSPITAL

Occupational Therapy

Medical Aids Subsidy Scheme

Palliative Care Equipment Program

This a program administered under the Queensland Department of Health Care. The program provides equipment on a loan basis for up to 6 months.

Your Occupational Therapist will discuss with you what equipment you require and submit the application on your behalf. All of the equipment will be funded through the program and will be provided by a local equipment supplier at no cost to you. It will be delivered to your home and set up for you. You will need to ensure there is adequate space for the equipment to be set up. For example, if you need a hospital bed, please make sure there is a bedroom or living space free and a power point available.

The equipment which has been ordered for you includes:

Please note, once recommended equipment has been agreed upon and the MASS PCEP application is submitted, equipment delivery can take up to **72 hours.**

When the equipment is no longer required, please call either the equipment company who delivered the equipment or Medical Aids Subsidy Scheme (MASS) directly on 07 3136 3636 or 1300 443 570 and ask to speak to the Palliative Care Equipment Program department.

You are welcome to provide feedback to MASS PCEP at any time during or after the loan equipment period, by emailing MASS-Equipment@health.qld.gov.au or calling 07 3136 3636.

Reference: https://www.health.qld.gov.au/mass/prescribe/palliative-care-equipment-program

The Wesley Hospital, 451 Coronation Drive, Auchenflower QLD 4066 PO Box 499, Toowong QLD 4066 Tel 07 3232 7000 wesley.com.au

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Version 1.0 Updated August 2020

Emily Mitchell, Suzy Smith,

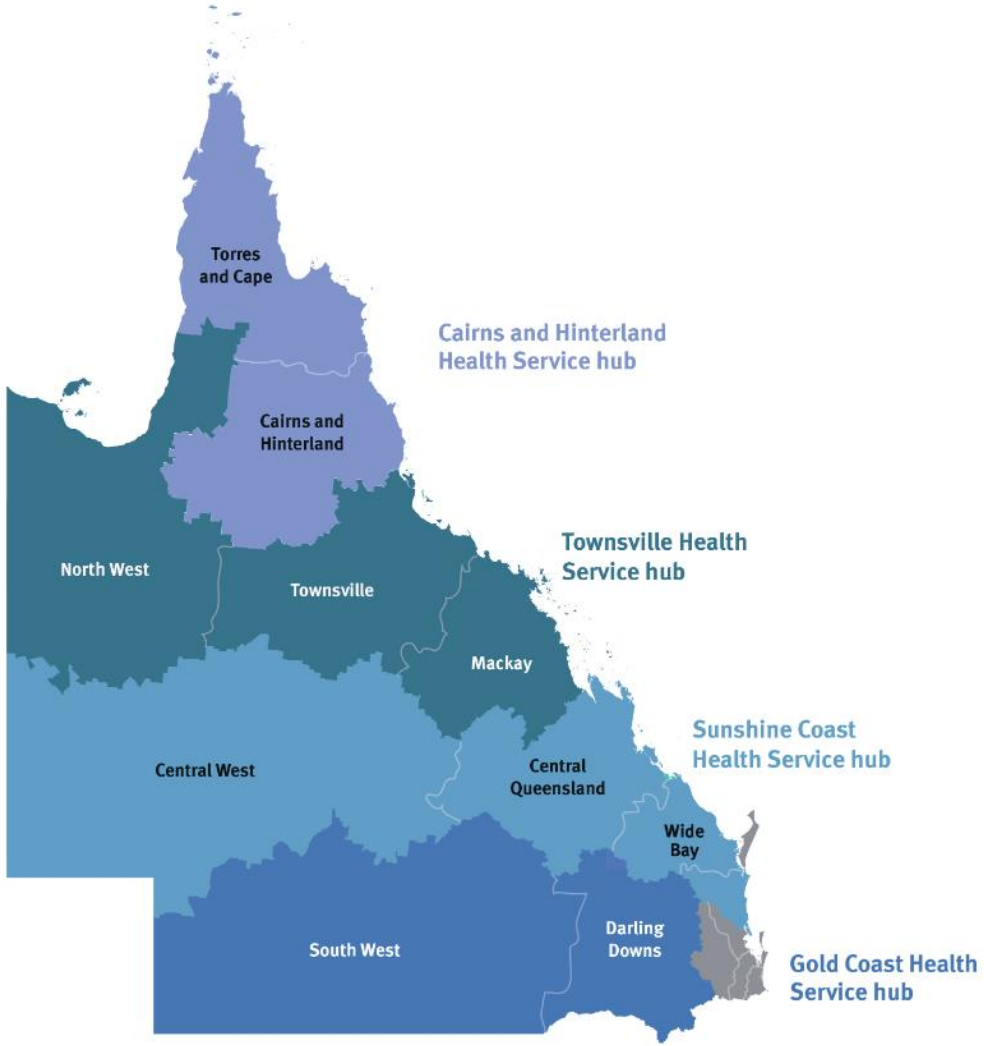
Ellen O'Connor,

SPaRTa – Gold Coast, Sunshine Coast and Townsville Hubs

Hospital, Community, Rural/Remote, Far North Queensland

Queensland Government

Service Overview



Specialist Palliative Rural Telehealth service (SPaRTa) is an interprofessional clinical service that provides telehealth consultations to palliative patients and clinical advice and education to local clinicians.

Key objective of service is to build local rural palliative care clinical service delivery through partnering with local communities to provide direct service provision and facilitate collaborative models of care.

- SPaRTa operates from four specialist telehealth hubs:
  - Gold Coast - supporting South West Queensland and Darling Downs, Gold Coast hub works in collaboration with Toowoomba palliative care team.
  - Sunshine Coast - supporting the rural regions of Sunshine Coast HHS, Wide Bay HHS, Central Queensland HHS and Central West HHS, Sunshine Coast hub works in collaboration with Hervey Bay, Bundaberg and Rockhampton palliative care teams.
  - Townsville - supporting the rural regions of Townsville HHS, North West HHS and Mackay HHS, Townsville hub works in collaboration with the Mackay palliative care teams.
  - Cairns - supporting the rural regions of Cairns and Hinterland HHS and Torres and Cape HHS, Cairns hub works in collaboration with the Pop-Up Palliative Care service.

Rural Practice Context Considerations:

Rural generalist model of care

- Clinician skill level and confidence varies from clinician to clinician
- Frequent changes to workforce
- Primarily outreach focused
- Skill sharing and delegation model
- Blue Care Rural and Remote funding

Practical strategies:

- Anticipatory intervention planning and ongoing collaborative communication
- Interprofessional clinical capacity building and skill sharing
- Developing good relationships with local equipment providers and local clinicians
- Facilitating access to acknowledgement and obligations form
- Adapting routine clinical assessment and equipment trial or prescription via Telehealth or shared care arrangement

Case Study – Client information

- Female "Daisy"
- 69yo
- Metastatic breast cancer (lung and bones spread). Presented to local rural hospital with headaches and photophobia.
- PMHx of T2DM, CKD, COPD, schizophrenia and bipolar disorder
- Lives alone, son and daughter in law are local (both work full time)
- Admission – CT head revealed large brain met with compression of 4th ventricle + R) occipital lobe. Started dexamethasone 12mg, weaning to 8mg by d/c (then 6mg etc). Hypothesis of leptomeningeal disease (due to photophobia) however unable to diagnose (no access to MRI and Daisy not wanting transfer or treatment).
- Consideration from the start of Daisy's trajectory
  - Lung mets – SOB, positioning needs, fatigue management
  - Bone mets – falls risk, pain, fatigue
  - Brain mets – cognition, vision, swallow (meals), impact on motor function, balance, weaning dex dose
  - Lives alone, family dynamics evident (? Likeliness of EOLC at home)
  - Independent on the ward with dex dose

Case Study – Equipment provided

- Equipment requested:
  - Over toilet frame
  - Shower chair
  - Recliner chair to assist with transfers
  - Manual wheelchair
  - Pressure relieving cushion
  - Over bed table (to be used with existing electric recliner chair)
- 4ww already in place
- Initial prescription from local OT (static equipment – applied through normal MASS). SPaRTa OT support for clinical management // extensive discussion and reflection considering diagnosis and trajectory – MASS PCEP application for other items.
- Specific equipment to support meaningful activity – MWC for community access with son. Complex family relationships and history, son unable to take on primary carer role however community access was achievable and meaningful.
- Did not request hospital bed or mobile shower commode as EOLC at home not the patient or family's plan. Preferred place of EOLC was local hospital.

Case Study – Reflections & Considerations

- **Key Learnings and Recommendations**
  - Daisy living in a rural setting, access to regular equipment deliveries is limited therefore kept trajectory at front of mind
  - Impact of medications and treatment on function (Daisy saw excellent improvement with dexamethasone however this was short lived)
  - Carer capacity is key for future planning (Daisy's trauma and mental health history had resulted in long standing relationship challenges with her family)
- **Do you have a "go to" piece of equipment?**
  - Pending the client goals (eg. EOLC at home vs hospital) - consider items that can support a range of goals. MWC with PRC can allow periods of time on outdoor deck at home + community access (social engagement with family at home + community engagement/appointments).
  - Often consider an electric recliner with pressure relief as a lot of our clients have symptoms that limit their ability to lay flat or sit comfortably, experience shows this is a versatile item to support a person's wishes, considers functional changes and meets their symptom needs (does not offer the same pressure care as a hospital bed, however person/family centred care approaches aid in this decision making).
- **Describe any problem solving/strategies you used with AT to achieve the patient goal.**
  - Local therapist introduced an over bed table to be used with the electric recliner, this made a big difference in Daisy's enjoyment of her time at home as she was able to comfortably set up her environment for longer periods of time as her function declined.

Practical Considerations –

Equipment Prescription

Funding is imperative (know your funding source)

- Private / HCP funding -? Implications for care/ initial use of MASS general / PCEP

(immediate needs vs fluctuating needs)

- Avoid items that duplicate
- Goals of care.

Logistical and practical considerations are taken into account.

- Ie. Time taken for ordering and delivered v's trajectory of decline. How much can fit in the person's home. How clinical does it need to look? Can we get away with less.

Carer needs are essential

- Do the carer's have any physical / mental / spiritual considerations that may impact your recommendations

Equipment options vs mods.

Navigating equipment conversations

Anticipatory planning: Have multiple plan Bs!

Value of provisional prognostication and applied knowledge regarding the rural practice context

Seeking permission to discuss patient and family understanding of current and future needs

Implementing change theory models

Education to support patient and/or carer recognition signs of deterioration and establish clear communication pathway

Equipment is only one tool in your backpack of interventions

Positive risk taking: Facilitate empowered decision making

Consider your wider team

Patient values and goals to inform priority of intervention and appropriate risk management strategies

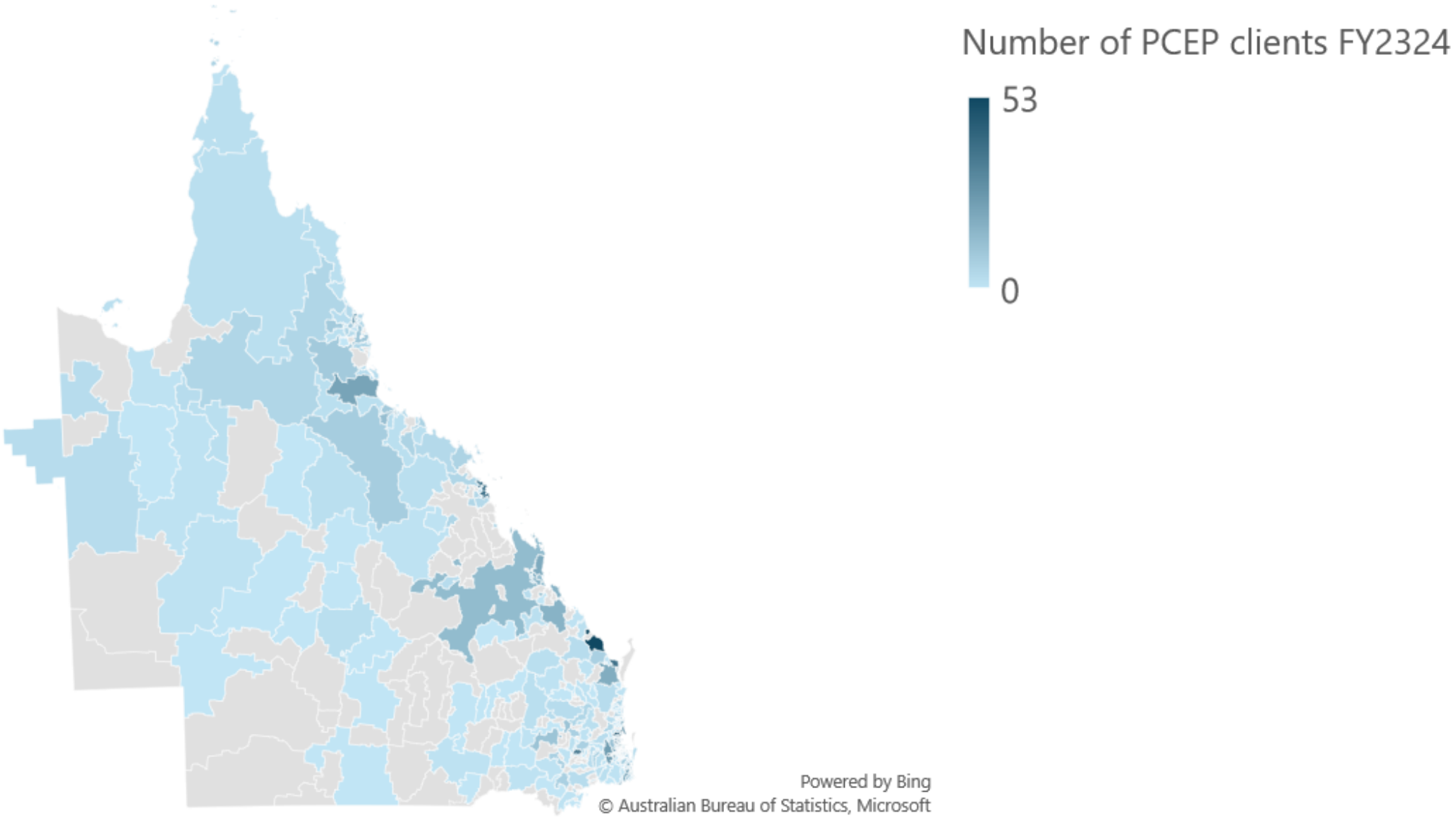
Enable patient choice and self-advocacy through strengthening patient or carer understanding

Collaborative goal setting regarding preferences throughout their disease trajectory or when approaching end of life.

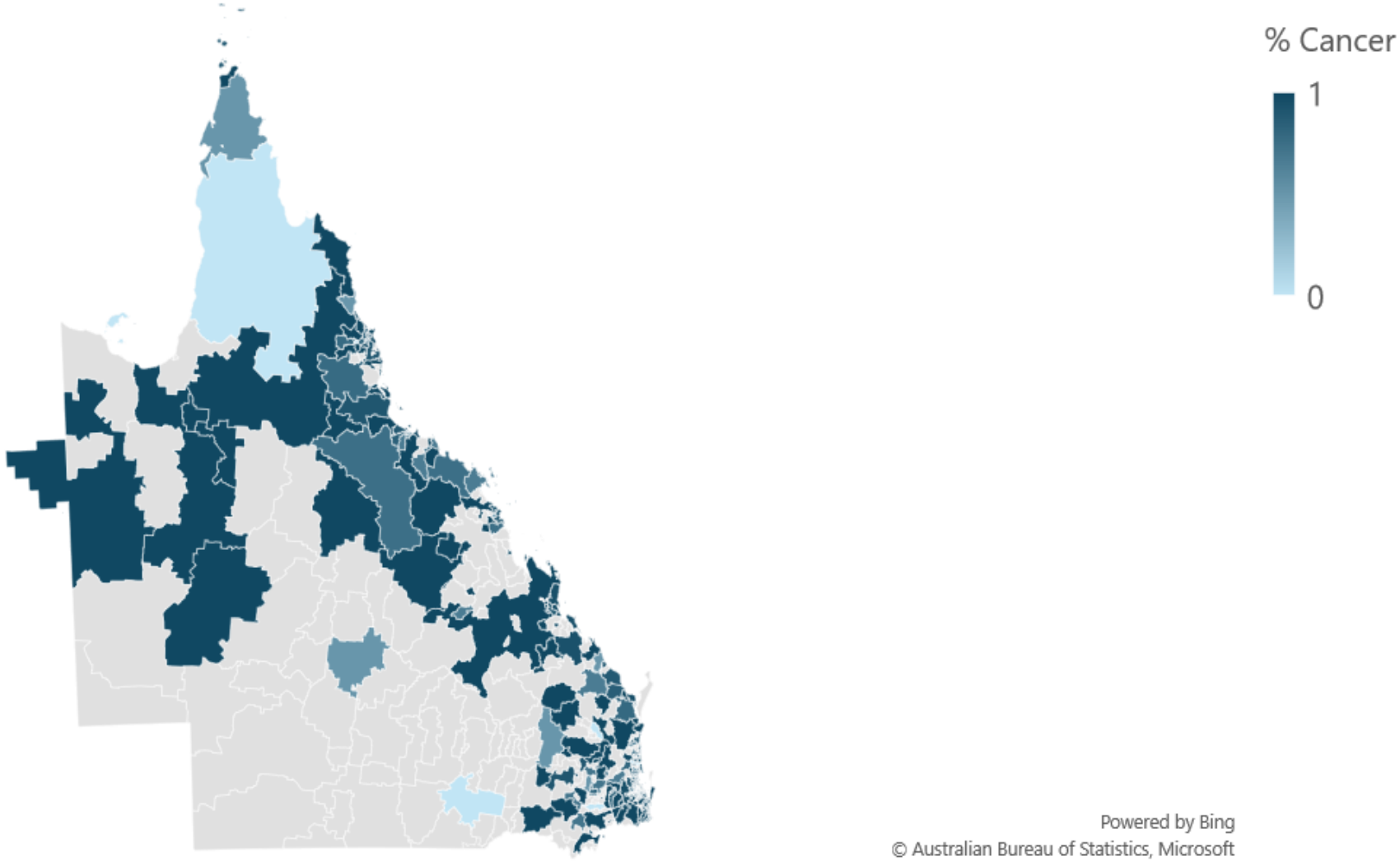
Key Resources

Microsoft Word - NECPAL TOOL_ENG_VF (gencat.cat)	Palliative Care Phases uow222232.pdf
CareSearch Health Professionals	Palliative Care Outcomes Collaboration - University of Wollongong – UOW
The SPICT™ – SPICT	Australia-modified-Karnofsky-Performance-Scale.pdf (spict.org.uk)
Palliative Prognostic Index PPI Pg101_PPI_EndofLifeBPG2011.pdf (rnao.ca)	The Palliative Performance Scale (PPS) | Palliative Care Network of Wisconsin (mypcnow.org)

Distribution of PCEP clients (FY23/24) by postcode



Percentage of PCEP clients with cancer (FY23/24) by postcode



Questions and Feedback

Complete the feedback form here to receive a personalised certificate of attendance

Thank you

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