

available caregiver. Upon admission to the program, patients received daily in-home nursing reviews supplemented by HITH medical consultations via telehealth. Palliative care physicians provided input through coordinated reviews at least weekly during admission, with increased frequency as warranted. Allied health support can be accessed depending on need and after-hours assistance was provided by HITH nursing and medical staff via telephone.

**Findings** Over the 9 months pilot phase, 10 referrals were made to the program and 4 patients were admitted. The patients who were referred all had a strong desire to return home for EOLC. Reasons for discordance between referrals and admissions to the pathway included rapid change in clinical status, change in discharge destination due to caregiver stress, and availability of alternative services to meet care needs. Of the admitted patients, one fulfilled their wish to die at home, one continued care at home with community supports, while two other patients had planned readmissions to the palliative care unit and managed to spend additional time at home aligned with their wishes.

**Lessons Learnt** The implementation of this pilot program has strengthened the relationship and collaboration between specialist palliative care and HITH services, which enabled support of patients with complex palliative care needs. There were several challenges including the uptake and integration within the broader service framework, partly due to limited awareness despite educational efforts targeted at inpatient services. Patient-related challenges included unstable symptoms and care needs, as well as rapid clinical fluctuations attributed to underlying disease progression, rendering program admission unfeasible on some occasions. Additional factors encompassed the limited availability and anxiety of caregivers in meeting the high care demands.

**Future Directions** The program remains ongoing, with a focus on continued education for hospital staff to enhance awareness of its availability. Referral sources have been expanded to include patients from other wards and an adjacent precinct cancer care hospital, and ongoing refinement of referral criteria is underway to optimize program efficacy.

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P-56

## RECOMMENDATIONS FOR IMPROVING QUALITY AND COST OF CARE FOR PATIENTS WITH LIFE-LIMITING ILLNESS

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It is evident that the cohort of patients who have a Life Limiting Illness (LLI) both globally, and in Australia, is significant.<sup>1-4</sup> It should go without saying that as our population's average age slowly rises, so too does this group of patients

whose medical needs and chronic conditions begin to mount. With such a significant collection of patients suffering with a Life-Limiting Illness, it is integral that our healthcare systems are aware of the best practise for how to manage such patients. Multiple rigorous studies have shown that the best practise for a patient with an LLI is a style of care that incorporates a palliative approach.<sup>5-9</sup> This has proven to improve patients' quality of care and decrease cost of hospital stay per patient.<sup>5 8</sup> These two metrics of quality of care and clinical cost per patient have emerged as key areas of interest in this field of study.

There is proof that tertiary centres around the globe and particularly in Australia are under-identifying these patients with an LLI, and therefore, there is a proportion of LLI patients being treated as patients without an LLI.<sup>2 10 11</sup> This under-recognition is leading to poor symptom management for such patients, and potentially unnecessary medical intervention in patients whose goals of care are poorly or not defined at all.

Accurately recognising patients with an LLI and treating them with more of a palliative focus not only increases patient satisfaction, it also leads to a reduction in overall cost per patient. This highlights a significant saving that could be made if tertiary care centres made a more concerted effort to appropriately identify and subsequently modify treatment for patients with LLI's.

This project will focus on recommendations for a tertiary centre and broader healthcare system to implement, such that we can better identify patients with an LLI. The goal being that if we can more accurately identify these patients, then we can make a positive impact on both patient satisfaction, and cost per patient.

**Results** Accurately recognising patients with an LLI and treating them with more of a palliative focus not only increases patient satisfaction, it also leads to a reduction in overall cost per patient. This highlights a significant saving that could be made if tertiary care centres made a more concerted effort to appropriately identify and subsequently modify treatment for patients with LLI's.

**Discussion** This project recommends the P-CaRES screening tool to be trialled and subsequently introduced to the emergency departments of tertiary centres within Australia. This tool looks to improve recognition of LLI patients by intercepting them at a common point of entry into the Hospital, with a goal of addressing and improving patient satisfaction, and additionally, decreasing overall cost per patient.

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