Ministry of Health Long Term Conditions Conference 2019

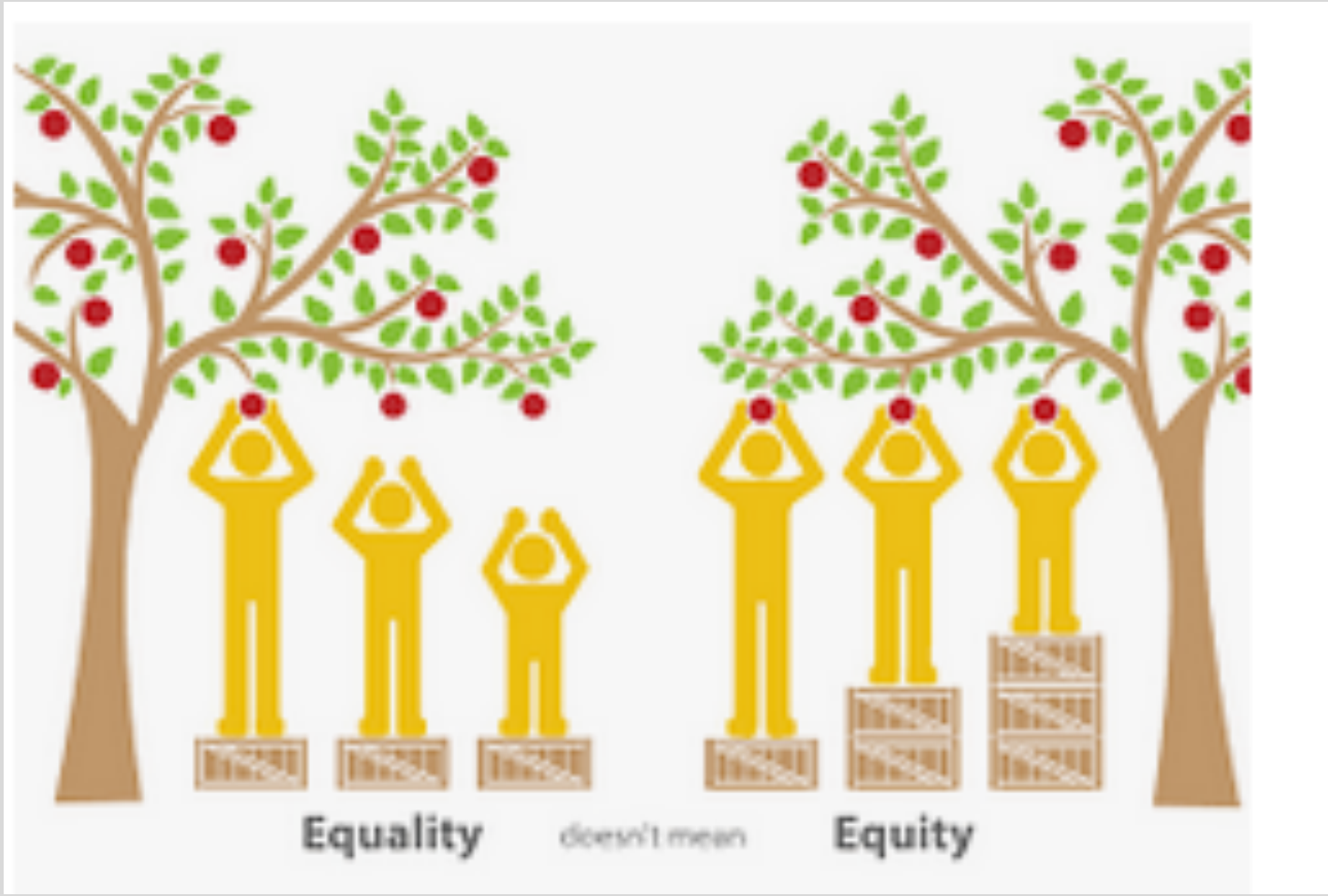
# ‘Take Two’ for equity in palliative care



Palliative Care for people admitted-to-die in Aged Residential Care:
a micro view

Palliative Care Governance :
a macro view

University of Otago
Te Whare Wānanga o Otāgo
New Zealand


Equality
doesn't mean
Equity

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# *Admitted-to-die in Aged Residential Care:*

## *Equity solutions for the care of those who die within 3 months of admission*

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Funding: University of Otago research grant

University of Otago
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New Zealand

Te Hopai Trust Group

# Background

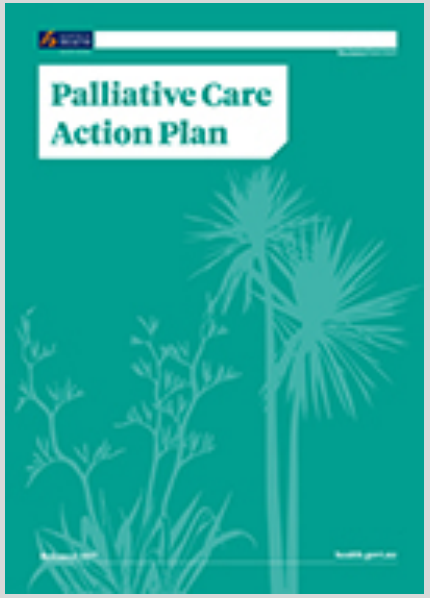
- **Hospice in-patient bed numbers static**
- **Secondary/tertiary hospital care inappropriate/costly for the dying**
- **38% of older adults die in ARC (Broad et al 2013)**

*"From 1998-2009 hospital level residents with a length of stay less then 3 months has increased"* (Boyd et al 2009)

*"High percentage of (deaths) in (ARC) **may be due to discharges of older people from acute hospital care to RAC near the end of life"*** (McLeod 2016)

^McLeod, H. (2016) The need for palliative care in New Zealand. Hammer Springs: Health McLeod & Associates and Ministry of Health
*Broad, J. B., Gott, M., Kim, H., Boyd, M., Chen, H., & Connolly, M. J. (2013). Where do people die? An international comparison of the percentage of deaths occurring in hospital and residential aged care settings in 45 populations, using published and available statistics. *International journal of public health*, *58*(2), 257-267.
Boyd, M., Connolly, M., Kerse, N., Foster, S., von Randow, M., Lay-Yee, R., ... & Walters-Puttick, S. (2009). Changes in aged care residents' characteristics and dependency in Auckland 1988 to

# Background: Palliative Care Action Plan




- Work with agencies, including regional health alliances, district health boards, hospitals, **aged residential care**, hospices, primary care, pharmacists and allied health services to understand impacts of population trends and palliative care scenarios on:
  - **palliative care services**
  - **operating models**
  - **commissioning models**

- Treasury's long-term fiscal modelling

- Recommend **one to three operating** (and commissioning) **models to investigate further**

- Agree on an **independent evaluation framework for the outcomes of the innovation funding proposals to improve the quality of palliative care in aged residential care**, primary care and community settings*
- Use **research and evaluation results to review quality dimensions for palliative care in aged residential care facilities**

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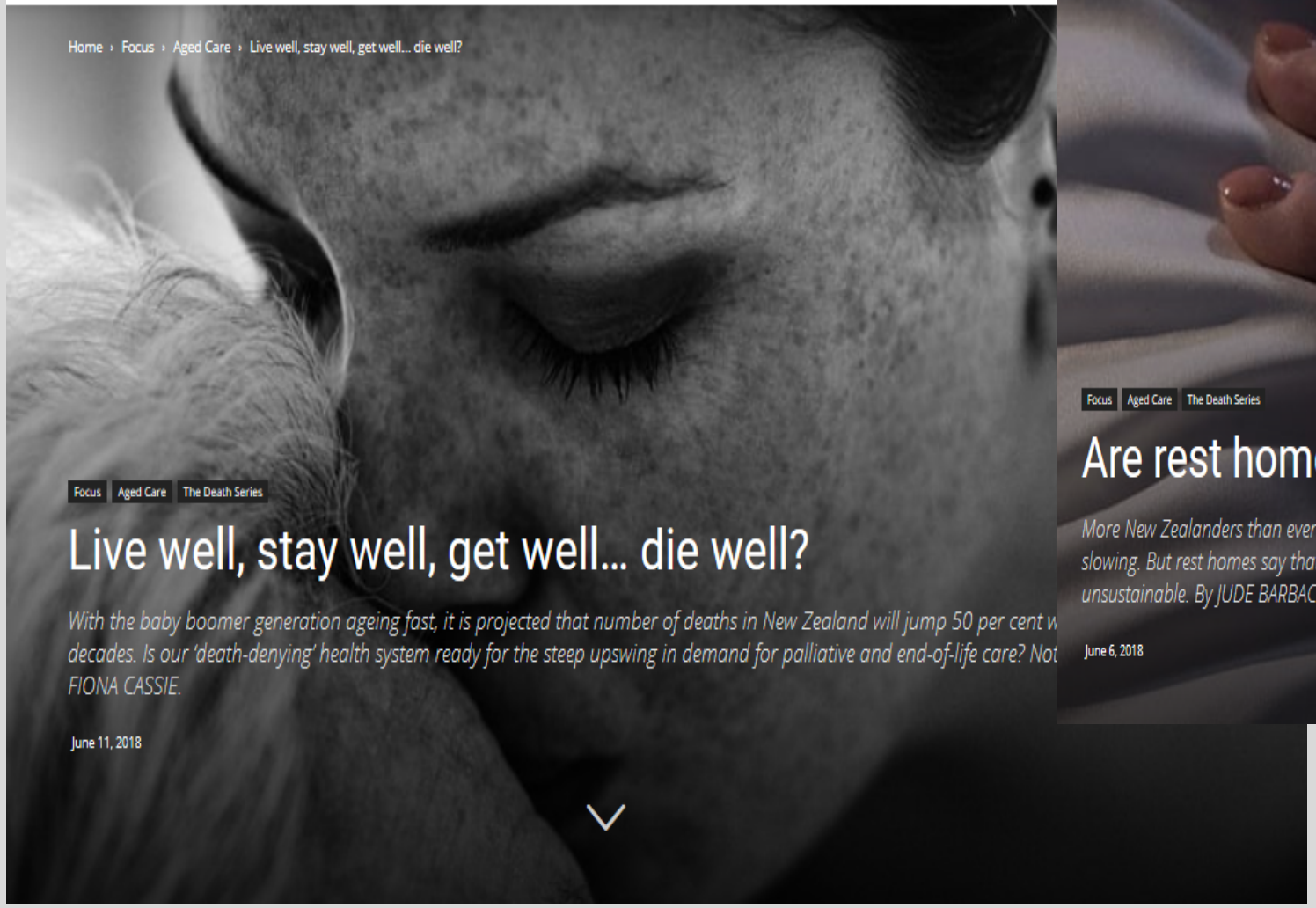


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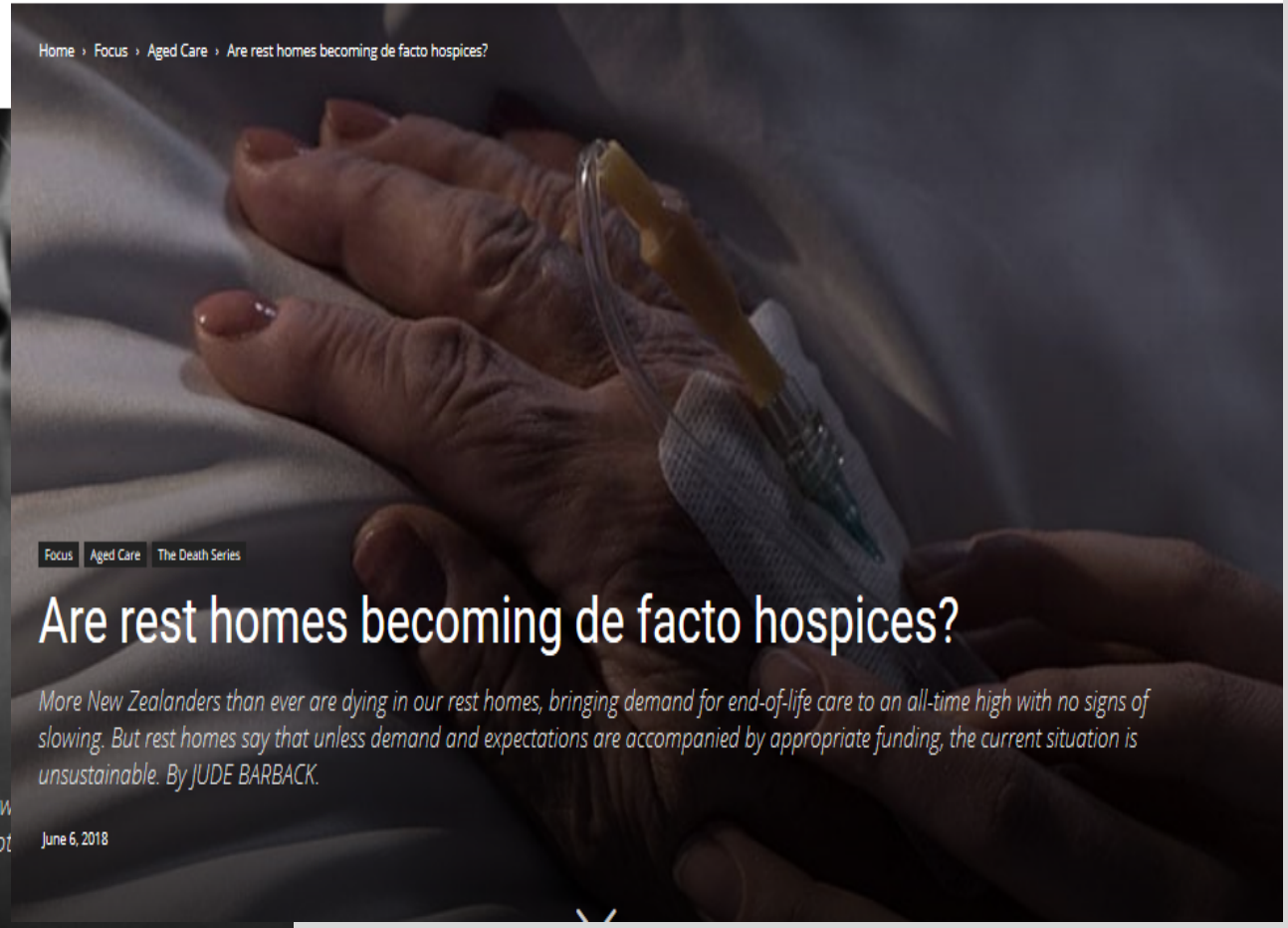

# Research

A case study: to establish the nature of cross-agency, integrated, inter-professional, collaborative palliative care for those ***admitted-to-die**** in ARC

Ethical approval: University of Otago (HD17/071)

# Methods

**Step 1. Chose a recognized high-performing ARC** as a partner

**Step 2. Focus Group:** Those involved in providing cross-agency collaborative palliative care **+ Interview:** ARC Manager

**Step 3. De-identified Notes Review:** ARC staff selected the records of 7 cases Inc < & > 65 yr olds in 2017 who died within days to 3 months of admission and received cross-agency collaborative care. (Most admitted from hospital or hospice)

**Step 4. Focus Group:** Agencies/services/external professionals involved in the care of 2 selected cases

**Step 5. Synthesis:** Three datasets


| Age |
| --- |
| Length of admission until death |
| Admitted from…. |
| Reason for admission |
| Enduring Power of Attorney (EPOA) |
| Advance Care Plan (ACP) |
| Professionals involved in palliative care |
| Anticipatory Care Planning |
| Medicines |
| Day to day record of patient's symptoms/distress |
| Care/support of patient + family (whanau) |

# Care for those ‘admitted to die’ is complex

Timeline – significant events relating t

29-09-2017
Admitted from
1x person assis
Referred Physi
Dentures
Continent
Puree diet, sw
NFR signed – n
Family request
PRN sevredol r
Overnight: Ass
Sevredol 10mg
“Pleasant” “jol
Sleeps in chair

30-09-2017
“pleasant, jolly” , but SOB and in pain, feet
PM: Sevredol given for pain
Overnight: Sevredol given for abdominal p

01-10-2017
Complaining of pain “getting worse”
PRN sevredol given in the evening and dur
V/B son BNO 3/7 – declined suppository, l

02-10-2017
Admitted by GP. Main pt. concern pain in
Husband passed away recently – married f
Increase Domperidone, Mylanta in evenin
Omeprazole and Simethicone stopped as r
Consider Buscopan PRN
Sevredol PRN X2
Consider biochemistry – will review notes
Electric chair organised for leg elevation

Medication on Admission:
**Regular**
Laxsol 3 tablets OD
Domperidone 1 tablet TDS
Colecalciferol 1.25mg once monthly

1 month daily; > 1 month weekly)

Mylanta
Midazolam
Clonazepam
Severdol
Laxsol
Lactulose

prior to meals

Medication Changes w Date and Mode of Delivery:

**PRN**
**Haloperidol (S/C):**
25-10 x1
**Buscopan (S/C):**
05-09 x1; 06-09 x1; 07-09 x1; 08-10 x1; 16-09 x1; 18-09 x1; 22-09 x1; 25-09 x3
**Morphine (S/C):**
05-10x2; 06-10 x2; 07-10 x1; 09-10 x2; 10-10 x2; 11-10 x2; 12-10 x3; 13-10 x3; 14-10 x2; 15-10 x5; 16-10 x2; 17-10 x3; 19-10 x1; 24-10 x1; 25-10 x4
**Cyclizine (S/C):**
08-10 x1; 17-10 x1; 18-10 x1; 19-10 x3; 2010 x3; 21-10 x3; 22-10 x2; 23-10 x2; 24-10 x4; 25-10 x1
**Sevredol (PO):**
29-02 x1; 30-09 x2; 01-10 x1; 02-10 x1; 03-10 x3; 04-10 x1; 05-10 x2; 06-10 x107-10 x2; 08-10 x3; 16-10 x1; 17-10 x1; 18-10 x3; 22-10 x3; 23-10 x1; 24-10 x1
**Lactulose (PO):**
02-10 x1; 05-10 x1; 14-10 x1

Further analysis needed re symptom control

WANT TO KNOW MORE?

SCROLL DOWN

# Structural, organisation, and contributing factors lead to inequity



1. Lack of system-wide agreement on equitable palliative care delivery
2. Current ARC funding level categories do not recognise the additional cost of delivering palliative care to those *admitted-to-die*
3. No health system funding for interprofessional, cross-agency collaboration
4. Variability in how DHBs fund/charge patients *admitted-to-die* in ARC
5. Lack of a common electronic clinical record to enable cross-agency communication

**And ARC environment barriers**

- **lack of appropriate clinical resources (syringe drivers, pressure relieving equipment);**
- **Physical layout that does not suit complex palliative care for either < & > 65yr olds**

# We need ARC to provide care to those *admitted-to-die:* equity solutions



- **ARC environment**
  - Best cared for in a **limited number of regional ARCs**
  - Should be **grouped together in a separate physical space**
  - Need a **key care coordinator**
  - Need **cross-agency collaborative care** to include a range of skill sets, with a **cross-agency electronic clinical record**
- **Funding**

  The selected ARCs should be **funded at a higher level** (to increase staff + provide special training. Staff should be provided support)
  - Funding for **contracted GPs to provide increased visits**
  - Funding for **specialist pharmacist input**

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# A case-study of a Managed Clinical Network for Palliative Care:

## lessons for equity-focused palliative care governance

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❄Phoenix Productions Ltd


Research Funder: HWNZ

University of Otago Te Whare Wānanga o Otāgo New Zealand

sapere

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# Background

Place of death: ARC and in the home rising- need for *primary palliative care* increasing#

Palliative care services: mixed funding model (DHB, MoH –Innovations funding, donations for hospice), DHB organisation

Stakeholders (patients & whanau, community, primary (inc ARC), secondary, tertiary, NGO, voluntary,)

*McLeod, H. (2016) The need for palliative care in New Zealand. Hammer Springs: Health McLeod & Associates and Ministry of Health

# Broad, J. B., Gott, M., Kim, H., Boyd, M., Chen, H., & Connolly, M. J. (2013). Where do people die? An international comparison of the percentage of deaths occurring in hospital and residential aged care settings in 45 populations, using published and available statistics. *International Journal of Public Health*, *58*(2), 257-267.

# Is the Managed Clinical Network Model an answer to organising regional palliative care provision?

*'linked groups of health professionals and organisations from primary, secondary, and tertiary care, working in a coordinated manner that is not constrained by existing organisational or professional boundaries to ensure equitable provision of high quality, clinically effective care'* (Baker & Lorimer, 2000, p. 1152)

MCNs intentionally include **clinicians**, managers and other stakeholders in a governance model to redesign/reorganise clinical service delivery. May include community, patients whanau

**Redesign/reorganisation involves measures to improve access, coordination and equity across government, professional, industrial, organisational and economic boundaries**

**Recognised defining features** of MCNs

# Is the Managed Clinical Network Model an answer to organising regional palliative care provision?

Research on MCNs has predominantly taken place in large countries. Little is known about how MCNs, as a form of governance, function in small countries.

(health services are relatively confined, geographically close and clinicians from different organisations know and work clinically with each other, stakeholders may jointly work to lobby for overall resources)

# Context of palliative care services in NZ

## Recognised inter and intra-regional variability in NZ for both *specialist* and *primary* palliative care service delivery

1. postcode/piecemeal palliative care provision depending on DHB area; 2. issues of access and equity

# Research

## To examine the development and implementation of a regional NZ palliative care MCN

Funder Health Workforce New Zealand

## What equity lessons can be learned from this research?

# Palliative Care MCN (funded by HWNZ)

Representatives of 11 local palliative care stakeholders (three DHBs, two hospices, one primary health care organisation and others)

Appointed Project Manager and Project Team hosted in the Joint Service Unit of the three DHBs (responsible for day-to-day operationalisation of the MCN decisions)

# Research methodology: independent formative and process evaluation

## A prospective, longitudinal (establishment, mid-point, completion), qualitative case study approach 2015- 2017

1. progress reports for the HWNZ and the MCN governance group
2. summary report
3. **research into the development and implementation of the MCN**

Ethical approval: University of Otago (D15/095)

*"It is what it is, and we have to do the best with what we've got, but it could be a whole lot better"*.

Lessons from this research

1. **Palliative care delivery is important**. Internationally, MCNs have successfully been used to address palliative care governance. In this case **the model did not enable agreement or commitment to a collective goal**

2. The MCN model **may not always work in small-country contexts**. The **less formal nature resulted in an inability to agree on vision and work collaboratively**

3. MCN members had **previously existing solid relationships when lobbying Govt together** but they struggled to work collectively when asked to **redistribute** financial, workforce and other resources between organisations to address equity issues. **Consider alliancing as a better option**

4. MCNs differ from other forms of governance because of the **mandated involvement of clinicians** but effective clinician input was problematic. **Train clinicians for governance**

5. **In NZ, palliative care governance needs representation from Maori, Pacific, patient/whanau/community and ARC as well as primary, secondary, tertiary and NGO sector**

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# Questions