Needs Assessment in Hospice Palliative Care – Staying Out of the Rabbit Hole

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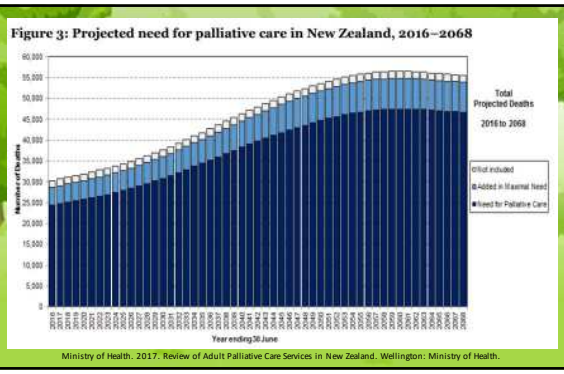
Christy Jackson & Joy Cairns
Clinical Nurse Specialists

Overview

- Discuss specialist palliative care "rabbit holes"
- A new service
- The year in review
- Identify service outcomes
- Highlight some strategic potential

Some Rabbit Holes?

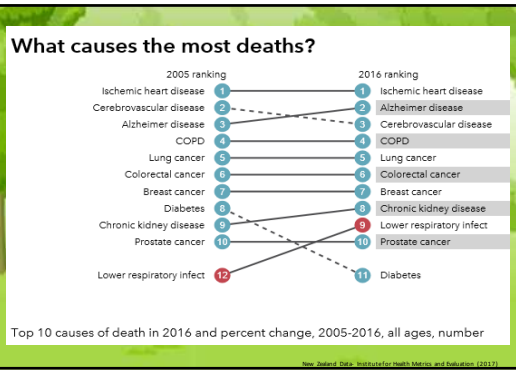
- Increasing population
- Increasing chronicity / frailty
- Morbidity is expanding
- Multi-morbidity the norm
- Mental health and dementia are growing challenges



Ministry of Health. 2017. Review of Adult Palliative Care Services in New Zealand. Wellington: Ministry of Health.

More Rabbit Holes

- Increasing demand vs capacity
- Accessibility to primary care
- Increasing need for support services
- Increasingly complex prognostication
- Equitable access for those with specialist palliative needs



Local context

- Bay of Plenty is a growing region
- Urban and rural mix
- Palliative = Waipuna Hospice
  - Waipuna "do everything" once referred
- Traditionally "once in, stay in"

Innovative Funding Project
Palliative Care Needs Assessment Team (PaCNAT)

- Assess referrals that do not clearly meet hospice specialist palliative care referral criteria
- Build partnership and collaboration with primary palliative providers across the sector
- Explore strategic options for future delivery of sustainable, equitable hospice specialist care for those who need it in a timely manner

Palliative care needs assessment team (PaCNAT)

- Core role to assess "grey" referrals
- Develop policy and processes
- Tools needed
  - Team
  - Hospice referral criteria
  - Holistic assessment process

- **Clinical Nurse Specialist and Service Coordinator** – Christy Jackson
- **Social Worker** – Lance Graham
- **Palliative Medical Specialist Oversight** – Carol McAllum
- **Allied Team**
  - **Counselling** – Penny Farry
  - **Chaplain** – Donna Denmead
  - **Whakamaru cultural support** – Tina Parata

PALLIATIVE CARE COUNCIL OF NEW ZEALAND

Referral Criteria for Adult Palliative Care Services in New Zealand

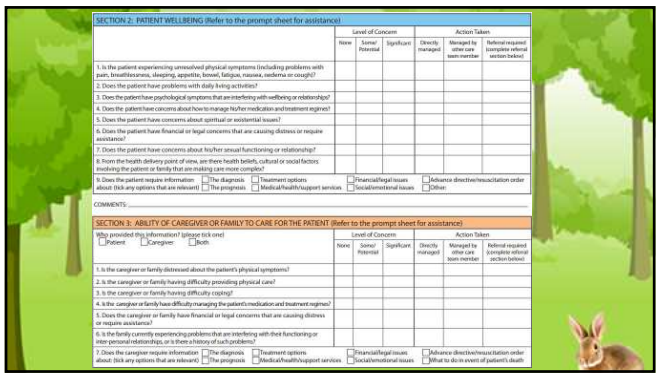
Based on the Leeds Eligibility Criteria for Specialist Palliative Care Services (Bennett, et al., 2000)

Patients must meet all five criteria below to be eligible for referral to Specialist Palliative Care (SPC). If there is any doubt about eligibility, the Referrer should contact the Service or Hospice to discuss further. It will be at the discretion of the Service as to whether patients who do not meet all of the criteria will be accepted.

1. The person has active progressive advanced disease, with a limited prognosis
2. **The level of need exceeds the resources of the primary palliative care provider**
3. The person agrees to the referral
4. The patient has New Zealand residency or has reciprocal rights, and is resident within the DHB.
5. The patient is registered with a local primary healthcare provider.

Holistic assessment - NAT:PD tool

- Simple, user-friendly and patient / whanau centred
- Aligns with Te Whare Tapa Wha model (Durie, 1982
- Robust, evidence-based, reviewed, objective,
- Needs rather than disease focused
- Informs care recommendations, goals of care and appropriate providers
- Reviewable


SECTION 2: PATIENT WELLBEING (Refer to the prompt sheet for assistance)

	Level of Concern			Action Taken		
	None	Some/ Potential	Significant	Directly managed	Managed by other care team member	Referral required (complete referral section below)
1. Is the patient experiencing unresolved physical symptoms (including problems with pain, breathlessness, sleeping, appetite, bowel, fatigue, nausea, oedema or cough)?						
2. Does the patient have problems with daily living activities?						
3. Does the patient have psychological symptoms that are interfering with wellbeing or relationships?						
4. Does the patient have concerns about how to manage his/her medication and treatment regimes?						
5. Does the patient have concerns about spiritual or existential issues?						
6. Does the patient have financial or legal concerns that are causing distress or require assistance?						
7. Does the patient have concerns about his/her sexual functioning or relationship?						
8. From the health delivery point of view, are there health beliefs, cultural or social factors involving the patient or family that are making care more complex?						

9. Does the patient require information about: (tick any options that are relevant) ☐ The diagnosis ☐ The prognosis ☐ Treatment options ☐ Medical/health/support services ☐ Financial/legal issues ☐ Social/emotional issues ☐ Advance directive/resuscitation order ☐ Other

COMMENTS: .....

SECTION 3: ABILITY OF CAREGIVER OR FAMILY TO CARE FOR THE PATIENT (Refer to the prompt sheet for assistance)

Who provided this information? (please tick one) ☐ Patient ☐ Caregiver ☐ Both

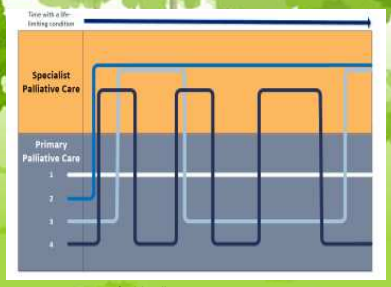
	Level of Concern			Action Taken		
	None	Some/ Potential	Significant	Directly managed	Managed by other care team member	Referral required (complete referral section below)
1. Is the caregiver or family distressed about the patient's physical symptoms?						
2. Is the caregiver or family having difficulty providing physical care?						
3. Is the caregiver or family having difficulty coping?						
4. Is the caregiver or family have difficulty managing the patient's medication and treatment regimes?						
5. Does the caregiver or family have financial or legal concerns that are causing distress or require assistance?						
6. Is the family currently experiencing problems that are interfering with their functioning or inter-personal relationships, or is there a history of such problems?						

7. Does the caregiver require information about: (tick any options that are relevant) ☐ The diagnosis ☐ The prognosis ☐ Treatment options ☐ Medical/health/support services ☐ Financial/legal issues ☐ Social/emotional issues ☐ Advance directive/resuscitation order ☐ What to do in event of patient's death

PaCNAT process

- Comprehensive interdisciplinary assessment
- NAT:PD and care recommendations developed
- IDT discussion
- Needs assessment outcome actioned
  - remain primary care (not admitted)
  - funded visit for discussion with GP
  - accepted to Waipuna Hospice services
  - "episode of Waipuna Hospice care"

Needs-based allocation to best fit palliative provider



Review of Adult Palliative Care Services in NZ, 2017

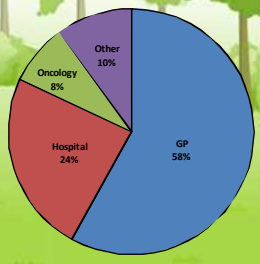
In a nutshell ….

To work in partnership with patients/whanau and their primary healthcare team to complete a comprehensive palliative assessment and care recommendations to determine which service providers are best suited to support the patient/whanau at this time.

year in review

1 August 16 – 31 July 17

Our people – the referrers



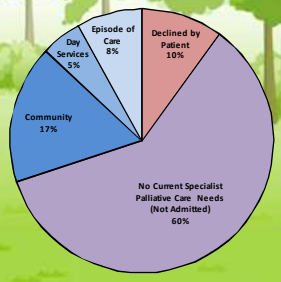
Our people – the referred

- 113 referred
- 19% of total referrals
- 53% female / 47% male
- 48% malignant / 52% non-malignant
- 100% domiciliary

Age (years)	Percentage
< 60	5%
60 - 70	18%
70 - 80	25%
80 - 90	33%
> 90	19%

Ethnicity	Percentage
New Zealand European/ Pakeha	76%
Maori	14%
Chinese	1%
Other European	6%
Unspecified	3%

Our people - outcomes



Case story

- Female
- 70's
- Severe COPD with associated anxiety
- 8 hospital admissions Feb – May 2017
- "reduce need for frequent admissions"
- Declining home support services
- Whanau stressed and wanting her to accept additional support

Benefits of the process

NEEDS ASSESSMENT

Needs assessment with coordination and care recommendations have emerged as a therapeutic single episode of specialist palliative care

GP Feedback

"She got exactly the assessment I was hoping for"

"Your team approach including yourselves, oncology, GP very useful and supportive of both patients and caregivers"

"Very useful and helpful"

"The process was therapeutic in itself for them. Feedback was good."

"Identified problems (present and potential) for discussion with patient when I see them"

"Could you please arrange one of those amazing home assessments for …"

"Thorough assessment of patient and carer needs"

Benefits of the Needs Assessment Tool(NAT:PD)

- Identifies needs effectively
- Quick, concise and visual
- Assists equitable needs based service provision
- Clearly understood by all health professionals
- Assists in clarifying most appropriate service provider for the identified need
- Reveals the goal of a specialist palliative episode of care

Benefits of PaCNAT service

- Highlighted value of comprehensive assessment in the referral process
- Building capacity and collaboration with primary palliative care providers
- Focusing on goals of care and service provision
- Using the existing services in primary health to their full potential
- Informing models of sustainable palliative care with seamless transition and care provision across services and agencies – "episode of care" / revolving door

So …….
is needs assessment a way of keeping out of the rabbit hole?

"Seriously ill patients and their families face major challenges in navigating and understanding their care plan within a complex and fragmented medical system … Palliative care programs, because of their interdisciplinary approach, assist patients and their families in understanding and gaining control over their care plans and in receiving further care in the setting most appropriate to their needs and resources"

Meier et al (2016), "Benefits, services, and models of sub-specialty palliative care"

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