Building Operational Excellence in Home-Based Palliative Care:

Access to Advice & Advance Care Planning: An Edmonton Perspective

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Alberta Health Services

PRESENTATION OVERVIEW:

- **Overview of Edmonton Zone Palliative Care Program**
- **Enhancing Care in the Community**
- **Access to Advice**
- **Access to Advance Care Planning**

OVERVIEW OF THE EDMONTON ZONE PALLIATIVE CARE PROGRAM

The Edmonton Zone Palliative Care Program

ENHANCING CARE IN THE COMMUNITY

Enhancing Care in the Community (ECC)

"*We are further investing in enhancing community care and **shifting from a focus on providing care in hospitals to more community-based care**, closer to home for all Albertans, ensuring the quality of care received is consistent and focuses on the needs and wishes of Albertans first.*"

Source: https://insite.albertahealthservices.ca/sh/Page16634.aspx

Alberta

Mar 20, 2017 Media inquiries

$200 million invested in community health care

Budget 2017 is boosting home and community care by $200 million, allowing more Albertans to receive care in their homes and remain independent.

Enhancing Care in the Community (ECC)

What Is Community-based Care?

"…brings together programs such as primary care, home care and mental and public health care as we know them today with other community and social supports like increased home care services, day programs, respite services, palliative services, community urgent response teams, hospital day programs and ***innovative approaches to assessments and system-wide case management.***

Source: https://insite.albertahealthservices.ca/sh/Page16634.aspx

Palliative Home Care

The Edmonton Zone Palliative Care Program

Palliative Home Care: Urban & Rural

Multidisciplinary Team

Palliative Case Management

Palliative Community Consult Team

Physicians, Nurse Practitioners & Nurse Consultants

Symptom Control & Palliative Care Team

Located at the Cross Cancer Institute

Palliative Consult Team

Located in the University of Alberta & Royal Alex Hospitals

6 Hospice Sites

85 spaces

5 organizations

Tertiary Palliative Care Unit

Located at the Grey Nuns Community Hospital

Urban Palliative Home Care

- Provides Palliative/End of Life Care services in the community setting for Urban Edmonton
- Services are delivered by an interdisciplinary team comprised of Case Managers, Nurses, Rehabilitation Therapists, and Social Workers, along with volunteers and support service providers – all with a palliative focus
- Twenty-four hour on-call nursing support is available

Urban Palliative Home Care *(cont'd)*

Enhancing Care in the Community (ECC) has resulted in additional team positions to support the shift of care from acute to the community:

- **Therapy Assistant (TA):** enables rehabilitation staff to work to full scope of practice and have a TA augmentation to support the care that community clients receive
- **Respiratory Therapist:** allows for dedicated respiratory services for palliative clients in the community – can assess and support caregivers and other team members on care decisions
- **Nurse Practitioner:** a new palliative specific role was created to enhance home-based access to advice for end-of-life clients
- **Systems Case Manager:** working to bring clients home from Acute Care who choose to pass away at home and require Palliative Home Care services
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- **Clinical Nurse Educator:** raising educational opportunities for staff and other stakeholders to support the needs of clients receiving palliative care in the home setting

Suburban/Rural Palliative Home Care

- The suburban/rural service delivery model differs slightly from urban palliative home care
- Palliative Case Managers have been introduced to the rural home care offices to better support palliative home care clients
- The Palliative Case Managers are integrated into the geographic home care networks.

ACCESS TO ADVICE

EZ Palliative Community Consult Team

- A specialized team of Physicians, Nurse Practitioners and Nurse Consultants who provide palliative care consultation for client in any Edmonton Zone community setting

- A **Physician/Nurse Practitioner led triage system** in both urban and rural areas to expedite referrals & access to 85 hospice beds in the Edmonton Zone (including the homeless population)

- The Edmonton Zone Community Palliative Care Program **palliative physicians are available 24/7 to provide support** via a provincial palliative on-call roster

EZ Palliative Community Consult Team *(cont'd)*

Assist in providing holistic care to the client and family with a life-limiting disease.

Assist physicians and other health care professional to control symptoms that the client may experience

Work closely with the Family Practitioners, Nurse Practitioners, Nurse Practitioners, Home Care Nurses and Hospital teams

Address symptoms and concerns of the client and family in the home setting, review Goals of Care Designations and may recommend transfer to the Tertiary Palliative Care Unit or to a hospice unit.

FAST FACTS:

- Average of 2012 palliative community consults are completed annually
- 68% of referrals for consult services are community-based
- 766 admissions to hospice annually (38% of total annual referrals)

Care of the Imminently Dying Pathway

Advice for staff in the acute, long term care or home setting…

- An evidence based tool to enhance quality of end of life care by:
  - Improving outcomes
  - Promoting safety
  - Increasing satisfaction with care
  - Optimizing the use of resources
- Guidance for any member of the health care team
- Utilized within any care setting, **including the home**

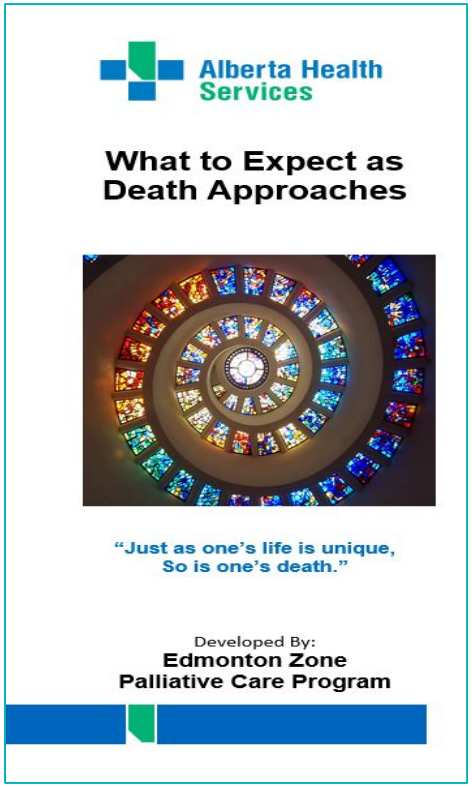
The Care of the Imminently Pathway includes:

1. Instructions
2. Initial Care Needs Assessment
3. C2 Medication and Care Orders
4. Nursing Symptom and Care Assessment and Documentation

Access to Advice: Resources

White Rose Program

Please stop at the nursing station prior to entering



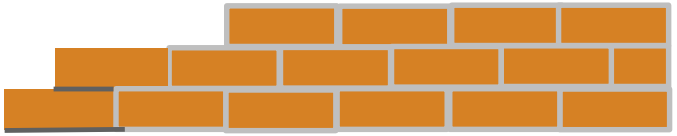
www.palliative.org

Resources available for order from Data Group

Access to Advance Care Planning

Policy, Procedure, Website, Workbooks, Advance Care Planning…

STRONG
FOUNDATION 4 ACP



www.conversationsmatter.ca

Advance Care Planning in Alberta

Advance Care Planning (ACP)

1. **Think** about wishes and values
2. **Learn** about own health
3. **Choose** someone to make decisions and speak on your behalf
4. **Communicate** wishes and values about health care
5. **Document** in a Personal Directive

Goals of Care Designation (GCD)

Medical order

Focus of care & location for appropriate medical care

Align values and beliefs with expert clinical advice

ONLY medical treatment

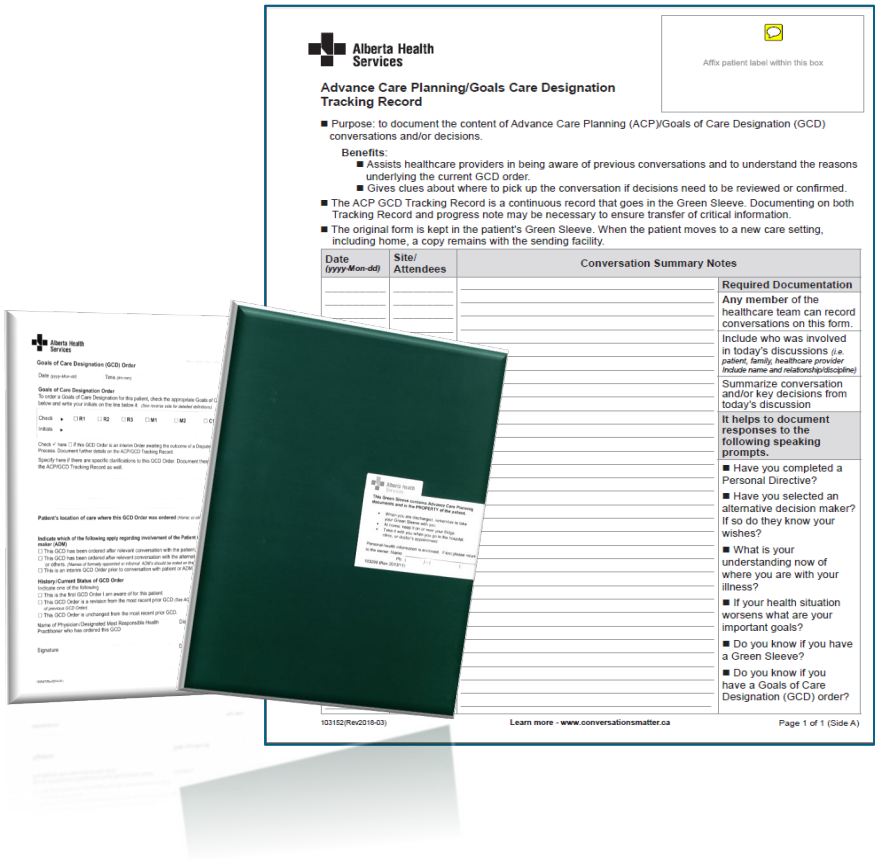
Ongoing discussion and wishes

Access to Advance Care Planning

ACP Conversation and Documentation: Role of all Professionals

Tracking Record

- All professionals can use it
- Document element of discussion / conversation
- Kept in the Green Sleeve
  - Also holds GCD and PD
  - Property of resident
  - Taken to medical appointments



Access to Advance Care Planning

Goals of Care Designations: RMC

- **Resuscitative Care** - Focus on prolonging or preserving life using medical or surgical interventions, including resuscitation and intensive care if needed

- **Medical Care** - Focus on medical tests and interventions to cure or manage a person's illness, but does not use resuscitative or life support measures

- **Comfort Care** - Focus on providing comfort for people with life-limiting illness when medical treatment is no longer an option

Access to Advance Care Planning

"Green Sleeve" Information for Clients

- ✓ Keep it on / near the fridge. Paramedics know to look there in a medical emergency
- ✓ Take it with you to medical appointments or if going to the Emergency Department.
- ✓ Share your wishes with your family.

Access to Advance Care Planning:

Serious Illness Conversations Guide

Bringing advice to clients and caregivers…

Earlier conversations about patient goals and priorities for living are associated with outcomes including:

- ✓ Enhanced goal-concordant care Mack JCO 2010
- ✓ Improved quality of life
- ✓ Reduced suffering
- ✓ Better client and family coping
- ✓ Higher patient satisfaction Detering BMJ 2010
- ✓ Less non-beneficial care and costs Wright 2008, Zhang 2009

Serious Illness Conversations Guide *(cont'd)*

- Too often patients with serious medical illnesses do not discuss EOL preferences, or first discuss them only in the last days to month of life
  Wright 2008, Dow 2010, Halpern 2011

- "Who" has the conversation "When"? It depends!

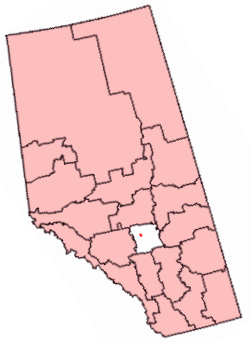
- Patients with serious illness have priorities besides living longer.

Serious Illness Conversations Guide *(cont'd)*

Recent Chart audits and interviews show that most clients had a GCD (87-95%), however:

- Calgary: LTC and SL residents:
  - Less than half (47 %) had documentation regarding participating in a conversation

- Edmonton: Acute Care: for seriously ill patients over 55 years:
  - 53 % had match between preferences and GCD
  - 16 % report being asked what is important



Simon et al.; Blondo et al

Serious Illness Conversations Guide *(cont'd)*

The quality of conversations support decision making

Conversation training & coaching

Gaining and honing communications skills

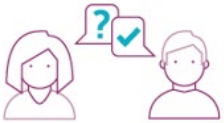
Patient ID

Finding the right patients

Reminder to clinician

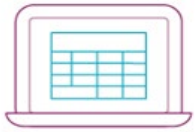
Knowing when to talk

Clinician/Patient conversation



Learning what's most important to patients

Documenting conversation



Making sure the information is easily accessible

Patient and family support

Providing patients and families tools to continue the conversation

Serious Illness Conversation Guide: Resources

Guidebook (7 languages)

GCD Poster

GCD Brochure