Canadian Home Care Association

High Impact Practices

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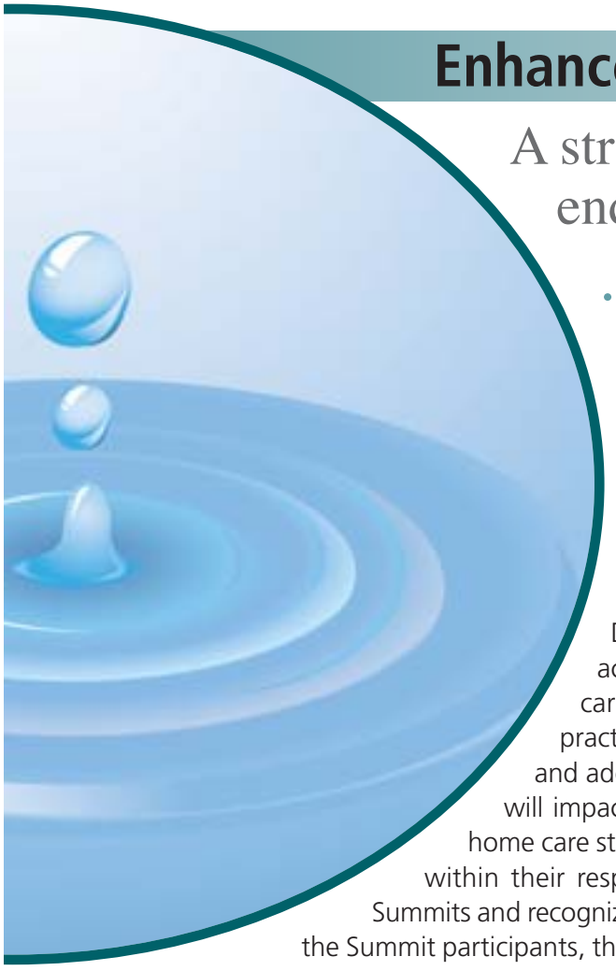

Enhanced Palliative Care Program

A strategy to enable timely access to end-of-life care

About High Impact Practices

The Canadian Home Care Association (CHCA), as a national voice, promotes excellence in home care through leadership, awareness and knowledge to shape strategic directions. The Association is committed to facilitating continuous learning and development throughout the home care sector to support and promote innovative and effective practices across Canada.

During the CHCA's annual Home Care Summit, health care leaders from across Canada and abroad share new and emerging approaches to home care and engage in dialogue about their experiences so that leading practices from across the country and, around the world, can be examined and adopted. Every year there are initiatives that stand out – those that clearly will impact the health care system. The potential of these practices is such that home care stakeholders want to hear more and are eager to explore the applicability within their respective jurisdictions. Building on the momentum of the Home Care Summits and recognizing the potential "ripple effect" of expanding the dissemination beyond the Summit participants, the CHCA has undertaken to document and publicize a selection of these innovative practices from across the country as High Impact Practices.

EACH OF THE HIGH IMPACT PRACTICES:

- **Promotes** home care that provides evidence-informed service delivery directed toward the achievement of health outcomes in the settings that best support the individual, and family
- **Enhances** the effectiveness of home care
- **Raises the awareness** of the ways that home care contributes to an effective health care system
- **Mitigates** rising health care costs and accentuates existing resources and expertise
- **Enables sharing** and transferring of knowledge, expertise and experience through networking and peer-to-peer learning.

Enhanced Palliative Care Program

Summary

Presented by the Hamilton Community Care Access Centre,[1] this practice demonstrates an effective home care approach to the provision of quality end-of-life care, a priority in Canada's 10-Year Health Plan.

The Enhanced Palliative Care Program at the Hamilton Community Care Access Centre (CCAC) helps people with a terminal illness to receive timely access to end-of-life care. The goals of the Program are:

- to relieve suffering and improve the quality of living and dying for people who are facing a life-threatening illness;
- to provide support for families;
- to meet an individual's or family's need for physical, psychological, social and spiritual care.

The Enhanced Palliative Care team includes the home care case manager, an advanced practice nurse (clinical nurse specialist or nurse practitioner), palliative care physician and spiritual care consultant. This core team serves as the clinical expert resource to the broader home care team, many of whom may have additional education and training in palliative care but who carry a general caseload. The Enhanced Palliative Care (EPC) team therefore helps to enhance the knowledge and abilities of the nurses, doctors and other formal and informal caregivers serving the client. The team is called upon to support clients with:

- Pain management symptoms
- Psychological issues
- Spiritual questions
- Life closure
- Other physical
- Social issues
- Practical issues
- Loss, grief

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"Hospice palliative care aims to relieve suffering and improve the quality of living and dying during the illness and bereavement of the client, family, and caregiver."

Canadian Hospice Palliative Care Assoc., 2002

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The Hamilton CCAC's EPC Program is meetings its goals. More clients are able to receive end-of-life care at home. The Program has demonstrated no increase in direct service costs per client except for shift nursing. However, the increase in shift nursing costs is offset by reduced costs to the health care system as a result of lower hospitalization rates. As importantly, clients and family feel supported and informed and feel that care is coordinated. Providers too, express feeling supported and satisfied with the care that they are able to provide as a result of the Program.

Community Care Access Centres (CCACs)

The CCACs are Ontario's home care programs. They are statutory corporations accountable to the Minister of Health and Long-Term Care. The CCACs provide a simplified service access point and are responsible for:

- determining eligibility for, and securing on behalf of consumers, highest quality best priced visiting professional and homemaker services provided at home and in schools;
- determining eligibility for, and authorizing all admission to all long-term care facilities;
- service planning and case management for each client;
- providing information on and referral to all other long-term services including volunteer-based community services.

The Hamilton CCAC arranges for services – nursing, personal support and homemaking, occupational therapy, physiotherapy, speech-language pathology, nutrition, and social work; medical supplies and equipment; and drug benefits – for approximately 10,000 clients per month.

For more information on the Hamilton CCAC visit, **www.hamilton.ccac-ont.ca**

Special thanks to the following individuals who provided advice, answered our questions and reviewed this paper:

Barb MacKinnon, Vice President Operations, Hamilton Community Care Access Centre
Jane Blums, Manager, Ministry of Health & Long-Term Care Central South Region
Melody Miles, Executive Director, Hamilton Community Care Access Centre

Project Background

As part of its commitment in the *10-Year Plan to Strengthen Health Care*, the Ontario Ministry of Health & Long-Term Care (MOHLTC) directed its home care programs to develop an integrated and interdisciplinary end-of-life care model within each CCAC catchment area in Ontario. The model was to be developed and maintained by those providing direct care. It was to achieve integrated and coordinated palliative care services; improved client access to end-of-life care; a coordinated point of entry and make the best technology application to support the model.

In 2003, the Hamilton CCAC launched, as a pilot, its Enhanced Palliative Care Program. This Program was designed to enhance the service offering of the CCAC in a way that provided more comprehensive and integrated care at home for palliative clients. Recognizing that home is typically where palliative clients want to be, the CCAC's Program was designed to improve the capacity of the community, which was faced with human resource shortages (physician and nurse particularly); and gaps in services. The goals were to help clients reduce the number of exacerbations of symptoms that resulted in an emergency room visit or hospitalization; to provide clients with palliative symptom management so that they could be comfortable at home; and to help the clients, their families, and the staff in the community feel better equipped to address the complex care needs associated with their palliative condition.

A clinical nurse specialist in Ontario is a 'general class' RN within the College of Nurses of Ontario (CNO). In addition to completing basic training, the clinical nurse specialist has pursued specialization in a particular area which involves acquiring in-depth experience and training in the specialist area (and often the acquisition of specialist qualifications).

A Primary Health Care Nurse Practitioner (PHCNP) is registered in the CNO extended class. The PHCNP has additional educational preparation for advanced nursing practice in primary health care to individuals of all ages. The PHCNP has an expanded scope of practice and advanced knowledge and decision-making skills in health assessment, diagnosis, therapeutics, health care management and community development and planning.

While advanced practice nurses (APN) – particularly, Nurse Practitioners, have been involved in primary care for some time, their involvement as a member of the home care team was, and still is, a new concept. Furthermore, CCACs have not typically contracted physician and spiritual care services directly. Recruitment and retention of these individuals has been, and continues to be, a challenge due to human resource shortages, limited home care specific education, and compensation issues.

The objectives of the EPC Program include:

- Supporting a primary care model of practice – the family physician remains central to the client's care at home but is better supported and resourced through the Enhanced Palliative Care team
- Building community capacity – so that all members of the health care team feel better prepared and equipped through the effective transfer of knowledge from the team's expertise
- Relieving pain and other symptoms – so that clients have fewer readmissions to hospital for symptom management
- Coordinating care with an interdisciplinary team – so that the expertise is leveraged and maximized to the client's benefit
- Reducing psychosocial distress – by valuing the importance of spiritual care
- Sustaining informal care providers – valuing and supporting the volunteers/informal caregivers who are integral to care at home
- Offering timely access and choice of place of death so that community capacity does not become the factor in making the appropriate choice
- Providing care that is cost-effective – a key tenet of health care today is to demonstrate cost effectiveness

Implementation

Key components of the Enhanced Palliative Care Program

- **Screening/comprehensive assessment:** using the interRAI-Palliative Care tool
- **Specialist palliative care consultants:** includes Advanced Practice Nurse, Palliative Physician and Spiritual Consultant

- **Interdisciplinary palliative team coordinated care:** Palliative care case managers work with palliative care consultants and clinicians to ensure resource allocation is targeted to the needs of clients and families. Documentation through a common chart in the home facilitates communication amongst the team
- **Psychosocial/spiritual support and counseling:** Partnership with supportive care services in the community such as chaplains and social workers and a Spiritual Care Consultant to address questions of meaning, purpose and hope
- **Caregiver relief/in-home respite care:** Focus on working with volunteers and optimizing the use of personal support workers for in-home caregiver relief
- **Provider education:** Consultation/advice, role-modeling and mentorship to primary care providers

Criteria for Hamilton CCAC's Palliative Program:

- Death is anticipated within the next 6-12 months
- Client has an advanced progressive illness with symptom control or support care issues.

The Team in Action

CCAC case managers work in partnership with hospital and community health care providers providing case management to their clients who are eligible for home care services. In Hamilton, once a client is identified as palliative, the case management responsibilities are transferred to a specialized CCAC palliative care case manager[2] for ongoing service coordination and system navigation. This case manager visits the client and conducts an in-depth palliative assessment using the interRAI-Palliative Care tool.[3] The case manager explains the Enhanced Palliative Care Program to the client/family, advises of the support available to them through the CCAC and how best to contact the home care team.

Should the client experience problems that the home care team cannot handle, a referral to the CCAC EPC team is made. The EPC team serves as a resource to the providers, the client and informal caregivers.

The APN triages all referrals to the EPC team. Based on assessment, experience and consultation with the family physician, the APN determines which member(s) of the EPC is best to address the client's needs.

The health care continues to be managed by the primary care physician – a key feature of this Program which ensures that the therapeutic and longstanding relationship with the family doctor is maintained and supported. The primary physician may consult with the EPC palliative care physician for advice on symptom management. After the initial consultation the EPC palliative physician stays in touch weekly, or even daily, through telephone discussions or visits with the client, their family, the family physician and the palliative team members.

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"We don't have scheduled visits ... we go as needed."

Palliative Care Physician

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The spiritual consultant is a non denominational practitioner who provides comprehensive psychosocial/spiritual support in order to foster a supportive and healthy atmosphere and facilitates the resolution of psychological and spiritual distress. In addition to supporting clients referred to the EPC, the spiritual consultant serves as a resource to staff and assists teams in their approach to ethical issues.

As does the EPC palliative care physician, the APN and spiritual consultant brief the primary physician regularly, usually verbally. In addition the EPC team communicates to the frontline clinicians and volunteers verbally as needed and through formalized team meetings. Written communication is through a common chart in the home. The client, family, informal caregivers and care providers are encouraged to use the chart as a means of documenting what happens between home care visits and for communicating with the team.

Once referred to the EPC team, the client remains on the caseload until death. The EPC team will follow-up with the staff and client's family up to three months after death. Because the Program is based on an "expert model", the Enhanced Palliative Care team may not visit the client regularly if symptoms are being managed successfully. They may function exclusively as a resource to the frontline clinicians (e.g. visiting nurses, physicians, therapists), raising their capacity to function independently in more complex situations.

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"The care and support for my mother has been astounding. It has allowed me to keep my promise to keep mom at home."

Daughter of client on EPC Program, Hamilton

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The EPC Program operates within the parameters of the Hamilton CCAC overall operations, which helps to ensure access to the Program. After-hours calls are supported through the CCAC's call service. Access to the client's CCAC case management file is through the organization's electronic records stored on a virtual private network available to case managers through laptop computers. Physician support is provided through a city-wide on-call roster comprised of the EPC Program physicians and their hospital colleagues. This physician coverage represents a partnership of the acute and home care teams to serve all palliative clients within the Hamilton region.

Caregiver relief is recognized and valued as essential to successful palliative care at home. The Hamilton CCAC offers up to the regulated maximums of shift nursing and personal support services to meet these needs. Palliative volunteer visitors through the VON Palliative Care Program and the Bob Kemp Hospice complement the CCAC funded service. When necessary, admission to the hospital is an option for clients.

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"Today when our team gets involved, the nurses know they have access to us and clients are better served."

Palliative Care Physician

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Continuing education of the team ensures that all members remain current and have a means to develop their area of expertise. The EPC Program works in conjunction with the Hamilton Hospice Palliative Care Network to offer education sessions for health care organizations and agencies drawing on the expertise of the CCAC APN, palliative care physician and other palliative experts in the community.

Evaluation

Evaluation is integral to CCAC programs. For this pilot, evaluation was conducted by independent researchers using CCAC, service provider and the Ministry of Health data; client records and client/caregiver interviews. The evaluation considered access, length of stay, place of death, relief of pain and symptoms, reduction in caregiver stress and perception of burden, client and family perception of the quality of end-of-life care, service utilization and costs. Comparative cost analysis was done using data for clients with lung cancer.

Findings

The evaluation spanned 1.5 years and consisted of two phases. Phase one reflected the introduction of the APN and phase two captured the involvement of the spiritual consultant. Of 796 clients on the Program, 76% had cancer. The average age was approximately 70 years. 69% of clients were on the Program less than 42 days and by phase two (a year into the Pilot) clients were 7.9% more likely to die at home.

Clients (20% were sampled) agreed that they were actively involved in their care decisions and most clients felt that services were well coordinated. The majority of clients reported that their health care provider made a difference in the pain and discomfort they were experiencing.

There was an overall cost savings to the health care system as the hospitalization rates for the clients on the EPC Program were reduced. Although the costs for shift nursing increased with the EPC Program, the analysis showed that clients received an average of three times the number of days of palliative care support on the home care program at an overall cost of half the estimated cost of a comparative hospital patient.

Outcome

The EPC Program continues to develop and evolve within the Hamilton CCAC. While human and financial resources challenge the stability of the Program, the CCAC, recognizing the merits, has committed to this initiative. Hamilton CCAC, as a partner in the Hamilton Hospice Palliative Care Network, continues to work to effectively respond to the growing demand for palliative care home care.

Key Success Factors

- The EPC team physician provides consultation only to the primary care physician thereby respecting the established therapeutic relationship; and avoiding burnout of the EPC team physician
- Specialized palliative care case managers with expertise in palliative care assessment, the identification and implementation of treatment interventions
- Dedicated home care consultants with expert clinical skills – nursing, medicine and psychosocial /spiritual support
- A willingness on the part of the broader health care team to work collaboratively and participate in continuing education for the betterment of care and service to clients at end-of-life
- Adequate resources, human and financial, to meet the needs of the palliative population
- Flexibility of clinicians and organizations to resource the client and their family so they can realize their goal of dying at home

The CHCA defines home care as an array of services, provided in the home and community setting, that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the informal (family) caregiver.

Conclusion

Hamilton CCAC's Enhanced Palliative Care Program is meeting its goals. More palliative people are able to die at home. Clients and families feel supported and informed and express that they perceive their care to be well coordinated. The EPC Program, as an expert model, fosters professional development of the health care providers and volunteers validating their contribution and energizing them to continue this demanding work. The effectiveness of home care, through a well resourced community team and a modest increase in shift nursing, to the health care system – from a cost perspective, and most importantly to the client's quality of life, is evidenced through the Enhanced Palliative Care Program.

For more information on the CHCA's High Impact Practices or other initiatives, contact **www.cdnhomecare.ca**

End Notes:

[1] Presented by Melody Miles, Executive Director Hamilton CCAC and Barb MacKinnon, VP Operations Hamilton CCAC.

[2] The palliative case manager serves adult clients only. Case managers specialized in pediatrics manage children's palliative care needs as required. Accordingly, these case managers participate in the palliative care training provided.

[3] More information on this instrument is available at http://www.interrai.org/section/view/?fnode=18

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canadienne de soins et services à domicile