Addressing current challenges & opportunities in End of life Care: The BC experience

Dr Doris Barwich
Executive Director,
BC Center for Palliative Care
May 2014
Doris Barwich

Relationship with Commercial Interests

I have no relationship with commercial interests.
Disclosure

I HAVE RECEIVED NO COMMERCIAL SUPPORT TO PARTICIPATE IN THIS SESSION.

THERE IS NO POTENTIAL FOR CONFLICT OF INTEREST.
Disclosure

I HAVE RECEIVED NO COMMERCIAL SUPPORT FOR THIS SESSION AND NONE OF THE COMMERCIAL SPONSORS OF THE OVERALL CONFERENCE WERE INVOLVED IN THE CONTENT DEVELOPMENT OF THIS SESSION.
Objectives

- Look at the FH End of Life Care (EOLC) Program & Hospice Palliative Care model
- Innovation and leading practices:
  - Telenursing
  - Advance Care Planning
  - Palliative Approach
- Uptake at provincial level: End of Life Care provision in BC
1.56 million people. 12 communities/12 acute care hospitals. ~10,000 natural deaths/2010 (30,000 in BC)

Program Management model with 20 clinical programs: Medical and Administrative co-leadership since 2010

Program Medical Director End Of Life Care 2001 - 2014
1996: Innovative plan for collaborative delivery of HPC services based on Edmonton model

Took $$ invested in 30 acute care beds in Simon Fraser Health region & created an alternative:

- 10 Tertiary beds
- 56 Hospice beds (one in each (4) community)
- $1 M for 4 community based HPC consultation teams (“in-reach” to hospital)
- $0.5 M for physicians, and
- $1 M to the bottom line
FH: Planning for HPC

- Funded in October 2001 and then…

- November 2001 3 Health regions => FHA
- Plan affirmed for FHA in 2002 with no new initial $$.
- Partnerships with Hospice Societies to build Hospices (FH operating $$)
FH MODEL: Services to support patients & families wherever home is 24/7
Hospice Palliative Care Services:

- 10 interdisciplinary consultation teams (CNS, MD, Clinical Resource Nurse/PRN, Social Work/Counselors, Volunteer Coordinator) : 24/7 support
  - After hours (9PM to 8AM) nursing support to pts/families in partnership with BC Health Link supported by Palliative Resource Nurse (PRN) on-call
  - Palliative care physician on-call coverage (3 groups)
- Integrated program in all settings of care. (Tertiary, Acute, Hospice, home, Residential).
- Contracts with Hospice Societies for volunteers and Bereavement services
- Physician contracts
Support for Primary care providers:
- Home health care nurses: Initial assessment and assessment re Equipment and supplies/ Medication costs (BC Benefits) & Home Support; Drug Boxes
- Ongoing education: Basic (395) & Advanced (345) HPC education plus “Acuity” day
- Family physician supports for ~30 %.
- Orphan Patient Program

Shared care and Consultation support (HPC MD 70%) for complex patients in all settings, as well as access to specialized beds (Tertiary Units or Hospice beds)
PROGRAM MODEL:

Unique community-based model:
- Integrated (Home, Hospice, Acute, Tertiary & Community) 24/7 Care which provides care to >40% of natural deaths (Benchmark 38%).
- 138 designated beds (30 Tertiary & 108 Hospice beds)
- 10 community-based teams
- Population-based model with leadership for EOL in all programs
FH stats: 2011/12

- 10,000 natural deaths
- 4510 new referrals (2700 in 2003)
  - 63% of new referrals from acute care
- 3498 deaths = 43% of non residential FH natural deaths
- Average program LOS: 80.4 days
- 30% non cancer diagnosis
Settings for “registered” deaths

- Hospice Residences: 43%
- Acute care: 34%
- Home Deaths: 12%
- Tertiary Hospice Palliative Care: 8%
  - LOS terminal admission 16.8 days
- Residential care: 1.8%
~ 60 physicians:
- 34 Consultants (CFPC & 1 FRCP with YAC).
  - 16 exclusively HPC (8 FT; 8 PT); Others (9) with part-time GP practices
- 26 “Associates”: Local GPs with minimum 30 hours of education with ongoing commitment to CME.
- (6-10 “Foster docs” take on orphan palliative patients: 30 hours of (sponsored) education)
Critical Success Factors

- Executive Support
- Business case around shift of $$ out of acute care
- Being seen as ready to go, collaborative and able to deliver innovative solutions
- Regional Leadership in place for ~10 yrs
- Currently “senior” role in FH & opportunities to influence others (EOL Working groups in most clinical programs)
Leading National practices:

- FH Symptom Management Guidelines: Adopted by numerous other HA’s and groups throughout Canada.


- Partnership with Hospice Societies: Multi-million $$ capital investments with significant savings to FH.

- Palliative Approach: End of Life Working groups in all clinical programs.
AFTER-HOURS TELENURSING

- After hours dedicated palliative nursing phone support for patients & caregivers developed in partnership with HealthLink BC in 2004. Support provided 2100-0800

- 2012 Expansion to all of BC

- Supported by Care at Home binder: Community nurse to ensure the patient’s up-to-date medication list & documented goals of care are available.
After-Hours Palliative Nurse Line

- Health Link manage 64% of calls with specialized call protocols
- 36% of call to PRN (Palliative Response Nurse) supported by FH symptom guidelines.
  - Family Physician: The physician’s number/availability will be recorded on the patient’s binder that is kept in the person’s home
  - If necessary, physicians will be contacted either by the FH Palliative Resource Nurse after-hours or during the day by usual Home Health service process
- Only 11% to ER
- Reports faxed to FP and HHC next am
ADVANCE CARE PLANNING: “Let’s Talk”

FH: Since 2004

- Development of My Voice© workbook, professional education (classroom & 2 on-line modules), DVDs, E Book, posters in 7 languages
- Making the MOST of conversations initiative: All clinical programs
- Materials adapted throughout Canada as well as USA, New Zealand, UK & Singapore.
- Winner: 2010 BC Patient Safety Quality Award for EOL Care
CHPCA National Framework for ACP

1. Engagement
   - Engage the healthcare system
   - Engage healthcare professionals/providers
   - Engage the legal system
   - Engage the general public

2. Education
   - Education and training of professional providers
   - Education of the general public

3. System Infrastructure
   - Policy and program development
   - Tools to support conversations and documentation

4. Continuous Quality Improvement
   - Continuous improvement

Patient/Family
Advance Care Planning (ACP) cycle

- **Advance Care Planning**
  - ACP Plan (My Voice)
  - Rep Agreement
  - Advance Directive
  - No CPR or DNR form

- **Goals of Care conversations**
  - Diagnosis/Prognosis
  - Anticipated/Feasible outcomes
  - Options for care
  - Plans for crisis

- **Documentation**
  - MOST form
  - ACP Record
  - Care Plans
Making the **MOST** of Conversations

**Medical Orders for Scope of Treatment (MOST):** A physician Order specifying scope of treatment in all sectors of care

**Advance Care Planning & Goals of care conversations integrated into routines of care**

**Advance Care Planning:** Tools & resources to support the public
Promote **best practices** around Advance Care Planning

1. **LOOK** for documentation re ACP: **Greensleeve** or **Meditech**

2. **ASK** about ACP: **SPEAK** mnemonic
   - **S**: Have they appointed a **Substitute Decision Maker**?
   - **P**: Do they have **Preferences** about their care?
   - **E**: Have they **Expressed** their wishes to family & **SDM**?
   - **A**: Do they have an **Advance Directive**?
   - **K**: Is there anything they would want to **Know** to help them plan for future health care?
3. **INFORM** & educate about realistic options & outcomes
   1. Diagnosis; Prognosis; Anticipated outcomes; Inter-disciplinary resources

4. **DOCUMENT** & communicate to other health care providers
   1. **ACP Record Form**: All health care providers in all settings to record ACP conversations over time.
   2. Medical Orders for Scope of Treatment: **MOST** form
   3. **Care Plans** to ensure care through transitions & crisis

5. **HONOUR** wishes (patient centered care)
**SECTION 1: CODE STATUS:** Note: CPR is not attempted on a patient who has suffered an unattested cardiac arrest.

- [x] Do Not Attempt Cardio Pulmonary Resuscitation (DNR)

**SECTION 2: MOST DESIGNATION** based on documented conversations (Initial appropriate level)

| Medical treatments excluding Critical Care Interventions & Resuscitation |
|-----------------------------|-------------------------------------------------------------------|
| _____ M1                    | Supportive care, symptom management & comfort measures. Allow natural death. |
|                             | Transfer to higher level of care only if patient's comfort needs not met in current location. |
| _____ M2                    | Medical treatments available within location of care. Current Location: ____________ |
|                             | Transfer to higher level of care only if patient's comfort needs not met in current location |
| _____ M3                    | Full Medical treatments excluding critical care |

**Critical Care Interventions requested.** NOTE: Consultation will be required prior to admission.

<p>| _____ C1                     | Critical Care interventions excluding intubation. |
| _____ C2                     | Critical Care interventions including intubation. |</p>
<table>
<thead>
<tr>
<th>Symptom Control</th>
<th>Resuscitation</th>
<th>Intubation</th>
<th>ICU</th>
<th>Site Transfer</th>
<th>Treat reversible conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>DNR M1</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>DNR M2</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>DNR M3</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>DNR C1</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>DNR C2</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>CPR C2</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
**SECTION 3: SPECIFIC INTERVENTIONS** (Optional. Complete Consent Forms as appropriate)

- Blood products: [ ] YES [ ] NO
- Enteral nutrition: [ ] YES [ ] NO
- Dialysis: [ ] YES [ ] NO
- Non-invasive ventilation: [ ] YES [ ] NO
- Other Directions:

---

**SURGICAL RESUSCITATION ORDER**

- [ ] WAIVE DNR for duration of procedure and peri-operative period. Attempt CPR as indicated.
- [ ] Do Not Attempt Resuscitation during procedure.

---

**SECTION 4: MOST ORDER ENTERED AS A RESULT OF (check all that apply)**

- [ ] CONVERSATIONS/CONSSENSUS
  - [ ] Capable Adult
  - [ ] Representative
  - [ ] Temporary Substitute Decision Maker

- [ ] PHYSICIAN ASSESSMENT
  - [ ] Adult/SDM Informed and aware
  - [ ] Adult not capable/SDM not available

- [ ] SUPPORTING DOCUMENTATION (Copies placed in Greensleeve and sent with patient on discharge)
  - [ ] Previous MOST
  - [ ] FH ACP Record
  - [ ] Provincial No CPR
  - [ ] Advance Directive
  - [ ] Representation Agreement
  - [ ] Section 9
  - [ ] Section 7
  - [ ] Other:
FH with BCHPCA Learning Center developed a 3.5 hour *Palliative Approach to Chronic Disease Management* workshop

- **Question:** *How to support primary care providers to integrate a palliative approach with chronic disease management (CDM) in the care of all patients with a life-limiting illness?*

- Literature search: Strong support for
  1. Role of the primary provider & GP in the provision of EOL care
  2. The need to move Palliative Care upstream and embed its principles & values in the care for all diagnosis
  3. Support for a practice support approach
Project Outcomes: Recommendations

- **3 themes:**
  - Build System Capacity for a Palliative Approach
  - Create Practice Supports
  - Implement Workshop Curriculum to promote change
- Project led to uptake by GPSC Practice Support Program
BC General Practice Services Committee Practice Support Program: EOL module (EOL PSP) targeting 33 – 50 % of BC GPs (~1000)

GOAL: Improve the care of patients & families living with, suffering & dying from life-limiting/chronic illnesses by promoting identification, assessment & communication/collaboration.

- Supported by development of tools & resources including electronic tools integrated into primary care EMRs
Palliative Care approach

- Palliative care is not a program.
- Palliative care can and should be provided by all care providers who care for the person and the family living with life limiting illnesses.
- Best approach is a collaborative one.
The Palliative Care trajectory

Disease-modifying therapies

Palliative Care Approach

Diagnosis made of life-limiting illness

Illness trajectory

Bereavement Care

Death
Would I be surprised if this patient died within the next year?
Palliative Approach through all the transitions

Patient Journey

McGregor and Porterfield 2011
Coordinated approaches…

- Better patient care - Improved quality
- Patients and families better informed of options and more satisfied
- Improved patient access to palliative care
- Reduced health system costs: Reduced ED visits, acute care LOS; fewer diagnostic services ($1,700 to $4,900 per admission)


A Knowledge Translation Project on Benchmark End-of-life Care Practices for the Elderly in Primary Care

PI: Dr Francis Lau and Dr Doris Barwich, MD (Jes Bassi, MSc)
Can the palliative approach that is integrated into the electronic medical record (EMR) of primary care physicians enhance EOL care in ways that are measurable, scalable and sustainable?
Objectives

- Increase uptake of benchmark end-of-life (EOL) care for elderly patients with advanced illness
- Develop quality indicators associated with best practices in EOL care based on the BC Practice Support Program’s EOL module
- Develop specifications to integrate indicators and proposed best practices into EMRs
- Disseminate best practices and resources widely to primary care physicians in BC
- Evaluate uptake and impact of EMR-supported proposed best practices on EOL care
Major Deliverables

- Determine baseline and benchmarks for current EOL care practices
- EMR specifications and resources for proposed best practices tailored to four EMR products
- Reported uptake and outcomes/impacts of proposed best practices
- Lessons and recommendations regarding next steps to promote uptake of the palliative approach to care and measurable outcomes
Reconfigure Home Health service bundles -> Palliative care pop’n
Outcome: Increase home deaths by optimizing community based options
Collaboration between:
› Home & Community Care: Defining competencies & supporting focused nursing practice
› Primary Care Division: Increasing involvement of Family physician
› Specialty palliative care team
**IPCC Prototype**

- **Care Management: “Primary care prototype”**
  - Palliative Focused Nurses (8 vs 30 staff) in community ~530 referrals/year; Additional Home Support
  - Initial assessment and then 10 min phone app’t booked with FP to enable collaborative care planning: Increased home visits; engagement
  - Home death rate from 8-14% in 1 year
  - Changing role of HPC team
Priorities for BC Health System

Meet Population and Patient Health Needs

Staying Healthy
- Supporting the Health and Well-being of B.C. Citizens

Getting Better
- Delivering a System of Responsive and Effective Health Care Services for Patients across B.C.

Living with Illness or Disability
- Ensuring Value for Money

Coping with End of Life

Goals
- Provide Patient-Centred Care
- Prevention and Health Promotion
- Primary and Community Care
- Improve Access to Specialist Services
- Access to Quality Diagnostic Services
- Access to Clinically- and Cost-Effective Pharmaceuticals
- Review and Improve Acute Care Services
- Appropriate Residential Care

Priorities
- Shared Plan of Action
- Clear Accountability
- Ensure Quality
- Skilled Change Management

Enabling Strategies
- Health Human Resources Strategy
- Information Management and Technology
- Budget Management and Efficiency
BC End of life Care Action Plan (2013):

- Redesign Health Services to Deliver Timely, Coordinated End of Life Care
- Provide individuals, caregivers and health care providers with Palliative care information, education, tools and resources
- Strengthen Health System Accountability & Efficiency
Specialist palliative care service delivery based on a population based approach with four delineated levels of care

- **Complex** (C)
- **Intermediate**
- **Primary care** (A)

**Level and role of specialist palliative care**

1. **Primary palliative care**
   - Provide learning and development opportunities for primary and secondary care providers

2. **Consultation – liaison**
   - Provide consultation and advice to primary and secondary care providers

3. **Shared care**
   - With primary and secondary providers

4. **Direct care**
   - In the community and in designated beds

Palliative Care Australia
Engage: Key stakeholders & partners: (UBC Division; GPSC; Impact BC; BCHPCA; IPANEL; CARENET)

Define: Vision and strategic plan
- To build capacity to deliver quality Palliative and End of life care in BC

Set up infra-structure & networks
Education, innovation, leadership
Questions???