

Notes from Collingwood Palliative Care session

June 6, 2016

Summary of Discussion:

Question 1: What do you think are the strengths of the current palliative care system in this community (Collingwood)?

- Local residential and visiting Hospice
- Didn't take long for the hospice to integrate into the community, for the community to accept it, and for the dollars to flow
- Strong partnerships and a strong sense of community
- Ability to identify patients early
- Providers approach to the promotion of quality of life
- Well established local hospice with a good reputation
- Excellent palliative care doctors; the doctors became involved with hospice early on, identifying processes and procedures, spending time in the hospice, encouraging family health team to become involved, they work on-call even without funding for being on-call
- What created a strong sense of community?
 - People are connected and committed
 - Having a residential hospice to "wrap" around
- Local EMR program is a potential resource that could be built on
- Local funeral homes are experienced with transition and supportive to families/friends
- 211; they help clients to find information
- Local Palliative Care Nurse Practitioner
- Skilled volunteers
- Robust amount of private paid services; meals on wheels, transportation services, etc.
- Local service providers levels of coordination and ability to work over geographical boundaries

Question 2: What are the opportunities to improve palliative care in this community?

- More beds in LTC and hospice
- More money for frontline staff and equipment, more care to the patient
- More use of free resources in the community to inform the community about resources; church bulletins, etc., different way to provide and access information
- Earlier identification of patients in need, public awareness
- One stop for resources online
- Improving the long waitlists for assessments, usually by CCAC, as assessment is required for access to certain services
- Increased funding to help reach hospices goals
- Sufficient and consistent number in health care navigators, have consistently the same navigators per patient
- Lack of people to manage the volunteer base
- Care giver support program has just been launched but need more (one day a week the care giver gets 5 hours as a break)

- People still associate palliative care with end of life and it's not end of life. We need to do more to educate and support patients and care givers at the beginning of the diagnosis process

Question 3: What 3 words or phrases would you use to describe your ideal vision for palliative care in this community?

- "Hospice is a center for coordinating all palliative care"
- "Timely, no waits"
- "Accessibility for all aspects, able to access the system, eliminating barriers"
- "Holistic care for the whole family"

Additional Advice for Creating Structure

- One size doesn't fit all, what works for one area won't necessarily fit for another
- Make it practical and aimed at patient and family
- Consider the ability of the organizations in the various communities to deliver it
- Start with the patient and what the patient needs, then decide what organizations we need to manage this frontline care.
 - If we did this, what is the sense of readiness for change in this community?
 - If it is positive for the patient then it will work well
 - Depends on the leadership that is leading the change, strong leadership has a vision of what palliative care means and can communicate to the community and explain the change in a positive way
- Communicate the plan to everyone involved and the patients and their families and make it practical
- Don't add bureaucracy, use what's already there and build upon greater patient-centred care
- Consider hosting virtual opportunities for further engagement with the communities

Summary from Submitted Worksheets:

Repeated Themes:

- Question 1
 - Campbell house has quickly been integrated into system
 - Strong pool of volunteers with professional and practical backgrounds
 - Interdisciplinary Community Rounds – Integrate project collaborative relationships – NSMH PCN, hospital, hospice, CCAC, Np's, physicians
- Question 2
 - Clear communication – avoid jargon
 - Money for frontline care – RNs/PSWs/equipment
 - Increased funding for Home Visiting Services

Question 1: What do you think are the strengths of the current palliative care system in this community (Collingwood)?

- 30 years hospice (community) experience

- 6 bed end-of-life care residence with 4 bed expansion starting – also increased community outreach programs – we will have increased physical space. This has raised awareness about hospice through patient/family experience
- Palliative Care Team meets weekly – identify palliative patients
 - Hospital
 - Hospice
 - CCAC
 - NSM PCN
 - RN service provider
 - Clergy and their needs
- Strong partnerships with health care providers
- Increased public awareness over years
- Close relationship with hospital
- Strong FHT engagement including 2 palliative care doctors
- Engaged Health Links
- Strong pool of volunteers with professional and practical backgrounds
- Support for fund raising well established
- Strong sense of community, belonging, increased awareness
- Local health network
- Hospice – strong image, volunteer strength, good family support
- EMR program possible resource
- Local interest groups ie: CARP information sessions
- Experienced and engaged funeral homes
- Community willing to support with dollars and support
- 211 is helping provide information but knowing where to find resources
- Hospice Georgian Triangle – Campbell house
 - Alternative to over-medicalized death
 - Raises awareness in community for palliative care
 - Congruent with spiritual view on end of life
 - Leader, example of excellence
- Palliative care nurse practitioner
- Strong chaplaincy program at hospital
- Parish nurse
- Well run 211 service
- Volunteers – lots and skilled
- Services – robust private pay services
- Variety of nursing homes, choices for location of end of life (hospice, hospital, LTC, home)
- Coordination/ability to work across geographical boundaries (NSM/SW) regions
- Funeral homes – pre-planning and bereavement support
- Expanding Campbell house (hoping for Bariatric bed)
- Visiting hospice – Volunteer navigator program – physicians
- Identify patients who are 6 months or less using 6SF question – referral to hospice – followed through journey

- Campbell house now running chronic disease self-management – this will help reduce fear and stigma with this
- Interdisciplinary Community Rounds – Integrate project collaborative relationships – NSMH PCN, hospital, hospice, CCAC, Np’s, physicians
- Holistic approach
- Spiritual support – large roster spiritual care providers
- Large base of volunteers
- Good community support – 50% funded
- Campbell house has quickly been integrated into system
- Physician support – excellent palliative care physicians
- Hospital and hospice – transition to home
- NSMHPCN resource nurse crosses settings
- Volunteer navigators – whole journey
- Bereavement and caregiver support
- Volunteer program
- Education across setup from network/hospice
- Campbell house linked to health links

Question 2: What are the opportunities to improve palliative care in this community?

- Earlier recognition and referral of life – limiting diagnosis
- Professional printed material for community distribution re. Cancer Care Ontario with its resources
- Sufficient (numbers) consistent navigation /patient for health care system
- Working with professional community service providers to support palliative people who are limited in their ability to getting to care and services ie: rural
- Possible virtual care program
- Increased funding for Home Visiting Services
- Outreach Inter-professional team
- Include alternate care modalities in treatment plan
- Transportation for day programs
- Better use of all free resources in the community info screens, newspapers, resources on radio
- Continuum of care early identification of who needs help in the community
- More coordination of online resources - one place to look for information
- More people to do assessments by CCAC
- More beds – LTC and hospice
- More hours – front line care
- Designating patients ‘palliative’ too late – reluctance to say ‘palliative’ to get extra funding for palliative care
- Money for frontline care – RNs/PSWs/equipment
- Quality care in nursing homes
 - Differences in quality of care between homes

- Clear communication – avoid jargon
 - More public education re: what is ‘palliative’, ‘Hospice’, ‘CCAC’?
 - What services are available and how to access them
- System navigation – people don’t know what they don’t know
- Credentials for parish nurse
- Top heavy systems
- Need more volunteers in Wasaga Beach
- Funding for 4 more beds at Campbell house
- Dedicated palliative care outreach team – hands on at bedside
- Support people to have a home death with increased resources
- Generalist basic level education in palliative care (very needed)
- Caregiver support teach logistics of caring, turning, who to contact
- More home care support – SW
- Increased PSW and nursing support at home, LTC and RH
- Chronic illness need a palliative care approach to care
- Chronic illnesses need to be identified
- ACP and Culture change regarding death and dying
- HSPs need basic level education
- Patient centered care
- HPC does not equal end of life care, lets end the stigma – marketing campaign
- RFP that has providers bound to QI in HPC

Question 3

- Hospice is the center for coordinating all palliative care
- Coordinated care, accessible, timely, reactive
- Accessibility (literacy and money)
 - 360 degree view – Holistic/whole person care
 - Clear, simple, transparent, processes
- Holistic care for the whole family that is available, accessible, equitable and timely