

**NORTHERN HEALTH
PALLIATIVE CARE STRATEGY
2015-2020**

April 2015

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Introduction

Northern Health (NH) provides a full range of health care services to approximately 294 188 residents of northern British Columbia and in northern British Columbia, approximately 1798 people die each year (Government of British Columbia, 2013). Of those persons who die each year, 90% would benefit from palliative care (PC) services and/or a palliative approach to their care (Carstairs, 2010). Palliative care is provided in all communities, in any setting (e.g. acute care, community, residential). NH tries to ensure that dying patients are provided the same quality of care regardless of where they choose to die.

Northern Health's 7,000 staff members provide services across a vast landscape that comprises two-thirds of the province. As the largest (geographically) health authority in British Columbia, Northern Health (NH) covers an area of approximately 592,116 square kilometers (Northern Health, 2014). Services are planned and organized by NH across northern British Columbia following a service distribution model that is oriented around normal flow patterns for services (e.g., business or recreational services) and the health needs of the northern population.

The support, operation and evaluation of the Palliative Care (PC) Program is the responsibility of senior decision makers and operational leaders in each Health Service Delivery Area (HSDA) (e.g. Chief Operating Officers, Health Service Administrators, Acute Care Managers, Residential Care Managers and Home and Community Care Managers). The vision for PC, aligns with the NH vision - "Northern Health leads the way in promoting health and providing health services for Northern and rural populations"- and reflects the NH Mission - "Through the efforts of our dedicated staff and physicians, in partnership with communities and organizations, we provide exceptional health services for Northerners" - by integrating and coordinating equitable access to high quality palliative care services for patients and their families living with a life-threatening or limiting disease.

Dying is a part of life and a 'good death' is a measure of the health of individuals, families and communities. Recognizing this, and the efficiencies resulting from a coordinated approach to care at the end of life, NH has developed a regional PC Program and is developing this strategy to plan and provide direction for palliative and end of life care for 2015-2020.

In 2013, the Government of British Columbia released *The Provincial End of Life Action Plan For British Columbia*, which outlines priority actions for end of life care. Work has been underway within NH for several years to align with these priorities. The NH PC Strategy is a key element of NH Seniors' Strategy and is part of the health authority's Primary and Community Care Integration work and contemplates how to best provide services within a rural context.

Guiding Principles

The following principles guide the NH Palliative Care Strategy:

- A person and family centred approach, longitudinal and team based care
- Palliative care in the location of the patient/family's choosing
- Service delivery within a rural and remote context
- A population health approach (e.g. employing upstream measures to prevent chronic disease, reduce the burden of chronic disease)

- Within the context of primary care homes supported by interprofessional teams a palliative approach to care is used (care in the right place, at the right time and by the right provider) when a person is diagnosed with a condition that will ultimately end their life, taking an upstream approach (iPanel, 2014)

“For society, a family’s suffering and the quality of their lives are a public health issue. By focusing on relieving suffering and improving quality of life, palliative care aims to promote health - physical, psychological, social and spiritual well-being - in everyone who is affected by illness and bereavement, including those who provide care. Our success will be a “determinant” of health in the 21st century (Lalonde, 1974).

Definitions

Good palliative care is a continuum of services provided in accordance with a care plan developed collaboratively between the person with a life limiting illness, the person’s primary care provider and members of the person’s care team.

Palliative Care: “Palliative care means the specialized care of people who are dying - care aimed at alleviating suffering (physical, emotional, psychosocial or spiritual), rather than curing. The term “palliative care” is generally used in association with people who have an active, progressive and advanced disease, with little or no prospect of cure” (BC Ministry of Health, 2006).

Hospice Palliative Care: “Hospice palliative care” is a philosophy of care that stresses the relief of suffering and improvement of the quality of living and dying. It helps patients and families to:

- Address physical, psychological, social, spiritual and practical issues and their associated expectations, needs, hopes and fears;
- Prepare for and manage self-determined life closure and the dying process; and
- Cope with loss and grief during illness and bereavement (BC Ministry of Health, 2006)

End of Life Care: “End of life care is associated with advanced, life-limiting illnesses, and focuses on comfort, quality of life, respect for personal health care treatment decisions, support for the family, psychological and spiritual concerns” (BC Ministry of Health, 2013).

Population Needs-Based Approach to Palliative Care: “Recognizes that individuals facing a serious illness have different needs, based on their unique health conditions, stage of disease and complexity of symptoms. Health care services and supports should therefore vary in type and intensity to most effectively meet the needs of the individual” (BC Ministry of Health, 2013).

Palliative Care Approach: Makes certain aspects of palliative care available to patients and families at appropriate times throughout the illness trajectory. After diagnosis and in the early stages of the illness the palliative care approach focuses primarily on:

- Open and sensitive communication about prognosis and illness trajectory;
- Advanced care planning;
- Psychosocial and spiritual support; and
- Pain and symptom management as required.

Later in the illness focuses on:

- Review of goals of care, and adjusting care strategies to reflect changes;
- On-going psychosocial support;
- Pain and symptom management; and
- Engagement of specialized palliative care providers as needed to address complex physical, psychosocial or spiritual symptoms (BC Ministry of Health, 2013).

Palliative approach requires upstream orientation to care delivery, adapts specialized palliative care knowledge and expertise and embeds it in care delivery, care processes and necessitates integration of care delivery (iPanel, 2014).

Designated Bed/Space or Service: *A designated bed/space or service* means that a target population is given priority access, but the bed/space or service may be used for alternate purposes or populations (BC Ministry of Health, 2015).

Dedicated Bed/Space or Service: *A dedicated bed/space or service* means that the access is reserved for a single purpose only. Dedicated spaces require stringent admission criteria as part of reserving access (BC Ministry of Health, 2015).

The continuum of palliative care is illustrated in figure 1 below. Palliative care can be provided early in a disease trajectory, regardless of whether disease modifying treatments are in progress. As the disease progresses and treatments are reduced, palliative care support increases, although it is important to note that both active treatment and palliative care can happen at the same time.

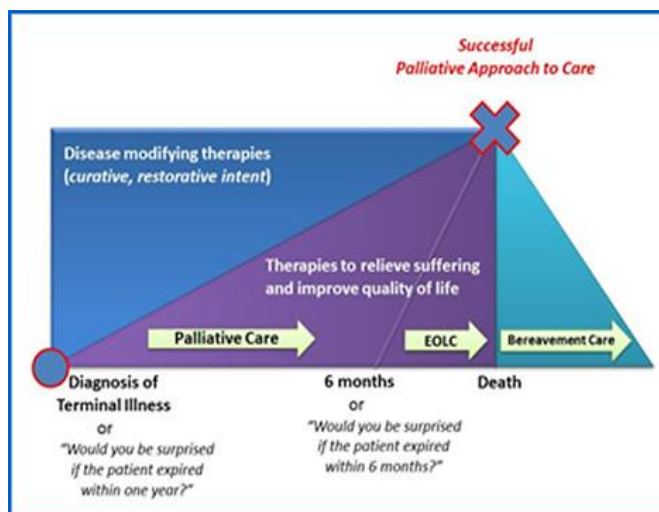


Figure 1 Adapted from the Canadian Hospice Palliative Care Association, Norms of Practice

Who Could Benefit from Palliative Care

A palliative approach is not limited to measures taken in the last hours or days of life rather throughout the entire illness trajectory. It should be viewed as the requirement for care and services that form part of the continuum from the point of diagnosis and can and should overlap with active treatment.

As stated previously, 90% of persons who die may benefit from receiving palliative care services and this includes persons diagnosed with both malignant and non-malignant disease. If you look at broad causes of death as sudden death, terminal illness, organ failure, frailty or other, with the exception of approximately 10% of deaths being sudden, all of the rest could benefit from access to palliative care (Carstairs, 2010).

Figure 2 shows disease trajectories for malignant and chronic disease. In the malignant disease trajectory, early palliative care using the palliative approach is stable and minimal, yet in the last stages of illness, palliative care needs intensify for a short period of time. Chronic disease trajectory is less predictable and it is difficult to determine if a dip in function may result in death. In dementia, the decline is slow, with smaller and more gradual dips in function. A palliative approach initiated by a primary care provider and interprofessional team early in the disease trajectory, allows for a more timely response to changing needs and allows more effective management of patient transitions.

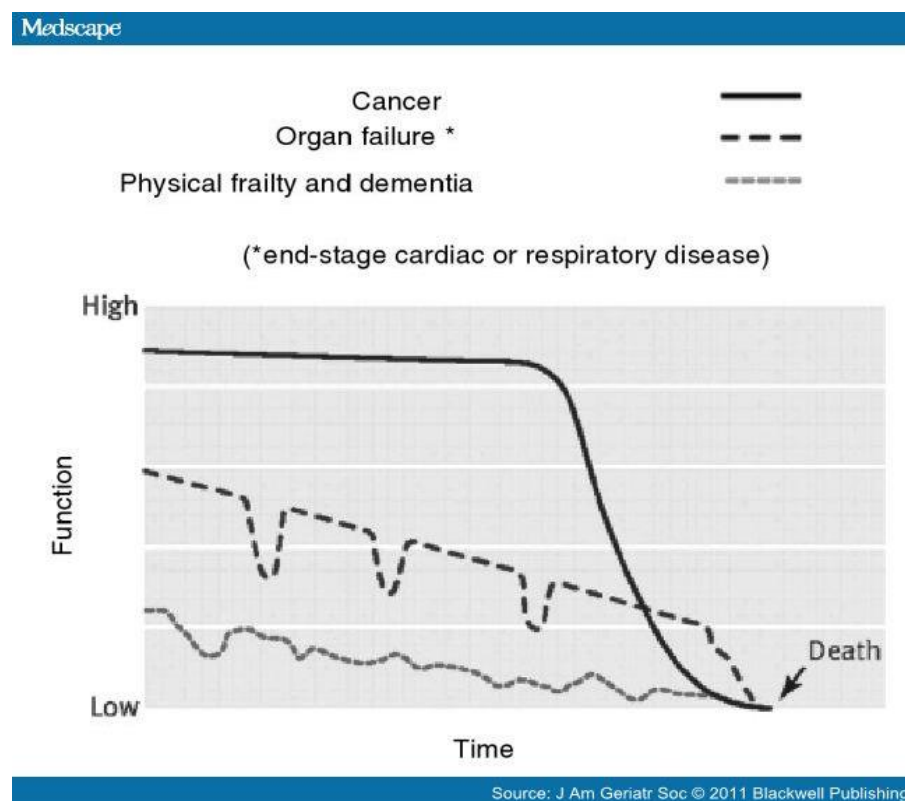


Figure 2 – Disease Trajectories and Palliative Care

The three most common illness trajectories requiring a palliative approach to care are cancer, organ failure, and frailty / dementia.

In all three trajectories, palliative approach can be used along the trajectory, regardless of the level of function. If we wait until the end of the trajectory to provide end of life care, we miss opportunities to plan and to improve quality of life and life expectancy. Palliative approach can be used, even in conjunction with active treatments.

Elements of the Northern Health Palliative Care Strategy

There is a rising burden of chronic disease, frailty, dementia, and population changes including an increase in our senior population (Appendix 1) that impact and influence planning regarding a palliative approach.

The strategy is embedded within the context of NH's Idealized System of Services (Appendix 2) and the NH Seniors' Strategy, recognizing that all palliative patients are not seniors. The overall goals are to improve access to palliative care, standardize the quality of palliative care, and promote the integration and coordination of care throughout NH. Ultimately, the goal is to provide quality palliative and end-of-life care to persons in the location of their choice, considering the rural and remote context that exists in the health authority. 90% of persons wish to die at home (Carstairs, 2010, Romanow, 2002). Through the establishment of person and family centred primary care homes supported by interprofessional teams, this strategy seeks to avoid "silos" that often create gaps in service and difficult end of life transitions for patients and their families through care planning and coordination of care. This strategy is underpinned by the use of a palliative approach to care for those living with a chronic disease, and patient/family centred care planning processes that are developed with the person and their family and to anticipate the wishes and needs of persons requiring palliative care well before a health crisis occurs. This strategy contemplates the use of a palliative approach to planning in seniors care, chronic disease care, and cancer care in all care settings. This plan will align with the NH Seniors' Strategy to ensure the points of interconnection and interdependence are well understood.

Being diagnosed as needing palliative care or a palliative approach in the days, weeks or months from death can no longer be the impetus for providing palliative care as people living with chronic or life-ending illnesses have "ups and downs" and may die "unexpectedly". A palliative approach should be integrated into care for all people with chronic, life-limiting conditions and should be provided by primary care practitioners early in the course of a chronic, terminal disease to address patient's needs (Canadian Hospice Palliative Care Association, 2015; iPanel, 2014).

Current State of the Northern Health Palliative Care Program

NH has a Palliative Care Program framework which was developed in 2011, that supports both the patient and family as the unit and centre of care. Care continues after the death of the patient with bereavement/support services for family and caregivers.

The NH Palliative Care Program framework provides guidance and a structure for all services in Northern Health offering palliative care, and ensures that standardized "best practice guidelines" for palliative care are followed when palliative care is being provided in any setting (e.g. acute care, community, residential). It ensures that dying patients are provided the same care regardless of where they chose to die, considering that 90% of people who die wish to spend the last months of their life at home and the unique challenges of rural and remote communities, using a population health approach.

In NH the delivery of palliative care is provided by interprofessional teams led by the family physician or a nurse practitioner. These professionals identify the issues, manage the

disease, and provide fundamental palliative care in the patient's own community. A primary care provider is anyone who provides care; this includes a variety of professionals from many disciplines, support workers, volunteers, family members or friends (see Appendix 3 and Appendix 4).

To support this local team, NH has adopted a consultative model of care. In this secondary level of care interdisciplinary teams of palliative care experts (NH Palliative Care Consultation Team) support and mentor primary care providers in every care setting where patients/families receive palliative care (Appendix 3). The following tables reflect some of the work provided by the Consultation Team in 2014.

2014 Consultations by PC Consultation Team - Report (**includes all formal/informal consultations over 5 minutes which include new, repeat and follow-ups)				
Period	NE	NW	NI	Period total
Jan 1-Feb 26	30	16	68	114
Jan 31-Feb 27	23	11	84	118
Feb 28 - Mar 31	34	6	97	137
Apr 1-April 24	25	6	41	72
April 25-May 22	20	3	74	97
May 23-June 19	19	1	103	123
Jun 20-Jul 17	33	2	48	83
Jul 18-Aug 14	42	4	76	122
Aug 15-Sep 11	25	3	81	109
Sept 12 - Oct 9	43	23	88	154
Oct 10-Nov 6	19	22	67	108
Nov 7- Dec 4	25	19	129	173
Dec 5- Jan 1	20	21	42	83
Total	358	137	998	1493
2014 Yearly Grand Total				1493

2014 Educational Statistics – Palliative Care Consultation Team			
Month	Attendance		
	# Participants Weekly Educational Webinar sessions	# of Formal education/ presentations	Video Recording (internal/external views)
January	57	23	
February	88	121	
March	42	77	
April	76	170	
May	88	30	9
June	37	39	196
July	36	12	100
August	55	17	140
September	35	6	123
October	38	41	102
November	29	117	90
December	N/A	N/A	75
Total	581	653	835

For each HSDA, the NH Palliative Care Consultation Team provides nurse consultant support. As well, a Palliative Care Pharmacy Lead and Physician Lead are available to provide consultative services to all Health Service Delivery Areas (HSDAs). All members of the Consultation Team work together to provide leadership and to contribute to all aspects of program development. This may include the development of clinical palliative care resources for care. Expanding the regional consultation services will be a focus over the next five years. (Appendix 3)

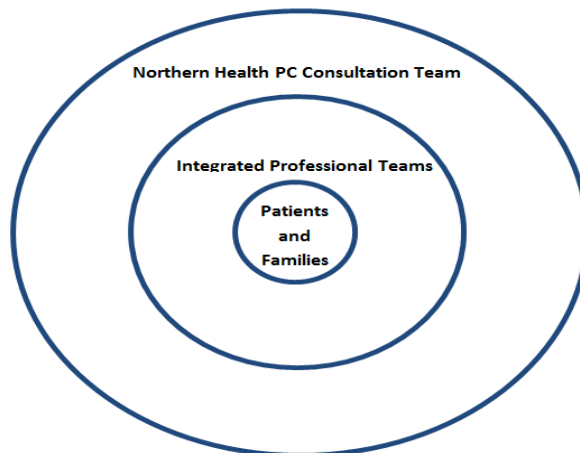


Figure 3 illustrates the NH Palliative Care Program Framework of Care

Northern Health partners with hospice societies and volunteers across the north in promoting advanced care planning, palliative care, hospice societies and volunteer services as well as education for the public on end of life care. The Northern Health Palliative Care Consultation Team collaborates with hospice societies in the provision of education to the public regarding palliative care issues, as well as providing leadership and education to hospice society volunteers and staff. An important focus over the next five years will be the strengthening coordination and partnerships with hospice and volunteer organizations.

The NH PC strategy reflects the values of NH, as well as the Canadian Hospice Palliative Care Association, BC Ministry of Health's *Provincial Framework for End-of-Life Care* (2006) and the BC's *Provincial End-of-Life Care Action Plan* (2013).

NH Palliative Care Framework - Organization and Functions

Strategic direction is provided regionally by the NH Executive ensuring that the NH PC Program aligns with the vision and mission of NH, NH's idealized system of services and other strategic planning processes (including senior's strategy and chronic disease strategies). The responsibility of the strategic alignment and interpretation of the strategic alignment is the responsibility of the Executive Lead, Elder Program and the Team Leader for the PC Consultation Team. The program will integrate information received through data collection and quality management to develop regional strategies and supporting policies to ensure competent and timely healthcare team involvement with the person / family through to death. Operational leadership of the NH PC Program is the responsibility of the Chief Operating Officers in each HSDA to ensure operational success. Each operational manager who has the responsibility of the care setting (acute care hospitals, residential care, designated beds in residential care, home and community care) providing palliative care is responsible to ensure the PC program, policies, best practice resources are followed, gaps in service identified and resolved in an integrative approach across all sectors. These operational managers report to their respective managers.

The Northern Health Palliative Care Framework Manual is a guide for all care settings providing palliative care. Providing PC services is the responsibility of all managers in all care settings providing end of life care. The framework outlines a consistent and standardized approach that all care settings and clinicians within these care settings will take to provide best practice palliative care.

How does the Northern Health Palliative Care Program Work?

To access identified palliative care services a patient must be registered with the NH PC Program to allow a broader set of services to be provided. Registration may be initiated by any healthcare provider with written confirmation by a physician. There are several criteria for registration for the program including:

- the patient is living with a life limiting or progressive illness;
- curative treatment is not the primary focus of care;
- the patient or representative has agreed to accept palliative care services and;
- the patient has a life expectancy of less than six months.

A central data base is maintained for all people registered with palliative status and this is maintained by the NH PC Consultation Team. This data is collected in order to monitor, evaluate and improve palliative care outcomes and services.

It has been recommended in the NH PC Program Manual that each HSDA has a PC Operational Advisory Committee to monitor outcomes and deliverables, identify gaps, promote collaboration, identify educational needs, be a mechanism for communication and to work with the PC Consultation Team in the development of best practice resources. Membership may consist of NH staff and external partners and stakeholders in palliative care. Currently the NE HSDA is operating an advisory committee and the Consultation Team will work with the other HSDAs to find opportunities to embed this practice in existing structures if at all possible and beneficial.

Northern Health Services Supporting the Provision of Palliative Care

- Strengthening home based palliative care through expanded consultative services and interprofessional teams.
- NH provides a variety of services that support palliative care that include: home based care for PC patients who choose to receive care at home including professional services (such as registered nurses, dieticians, social workers), home support services, medical supplies and equipment, BC PC Drug Program, home oxygen service, symptom management kit and planned death resources.
- Acute care/hospital based and community based resources are available if the patient and family desires, if care is unable to be provided in the community or if the patient's needs are frequent and require specialized care.
- Residential care- All patients admitted to permanent residential care beds have complex care needs and are acknowledged as being at the end of life or requiring palliative care. In line with the resident's wishes and the support of the family and staff the resident will remain in the long term care facility until death.
- Designated PC beds are located in a number of residential care facilities throughout NH as a means to improve the quality, access and integration of PC for patients who have a palliative designation. End of life patients are a priority for these beds.

The designated PC beds in residential care are located in:

- Fort St. John (Peace Villa)
- Dawson Creek (Rotary Manor)
- Quesnel (Dunrovin)
- Terrace (Terraceview Lodge)
- Smithers (Bulkley Lodge)
- Prince Rupert (Acropolis Manor)

Rotary Hospice House:

In partnership with Northern Health, the Prince George Palliative Care Society operates Rotary Hospice House; a ten-bed facility in Prince George designed to provide care to anyone who is suffering with either an advanced chronic illness, or a life threatening illness. NH will partner with and provide consultation and support for the Rotary Hospice House Staff to further develop their level and expertise. This will further enhance the excellent service being provided.

Additional resources and services are available in all care settings and include:

- Consultation, mentorship and education resources
- Clinical rounds resources

- Provincial After Hours Palliative Nursing Service (AHPNS) (for palliative home care clients only)
- Pain and symptom management resources
- Best practice guidelines
- Ethical guidelines for clinical decision making in PC
- Adult PC Order Sets
- Clinical decision tools
- Advanced care planning
- Caregiver support
- Volunteer programs
- Bereavement and wellness support

The Way Forward for 2015-2020

Over the next five years, Northern Health will continue the PC work it has been doing and expand the work to a broader audience (including the public, First Nations and specialized populations) and increase efforts to ingrain the palliative care approach throughout the health sector and into the community considering the rural and remote context and challenges. Specifically:

- Expansion of regional consultative services
- Strengthening home based palliative care through expanded consultative services and interprofessional teams
- Strengthening relationships with Rotary Hospice House and hospice societies

Provision of Palliative Care Information, Education and Tools / Resources

Community members should have easily accessible information to be well informed regarding palliative and end of life decisions. All health care providers should have a clear understanding of the palliative care approach and how to apply this information in their daily approach.

Target populations:

- Public/communities
- Health care providers

NH will continue to:

- Increase public awareness of the palliative care approach to care by continuing to manage website information, collaborate on campaigns with hospice societies, participating in health fairs and any other relevant activities;
- The PC Consultation Team will provide education on unique end of life (EOL) needs of specialized populations and promote excellence in EOL care and support for EOL care education including formalized education, mentorship and informal education for all health care professionals;
- Provide information and resources to support advance care planning;
- Collaborate and partner with hospice societies and volunteers across the north to promote advanced care planning, palliative care and hospice society volunteer services as well as education for the public on end of life care. The Northern Health Palliative Care Consultation Team will also continue to collaborate with hospice societies in the provision of education to the public regarding palliative care issues, as well as providing leadership and education to hospice society volunteers and staff.

NH will support provision of palliative care information, education and tools/resources by:

- Social marketing and promotion to shift public and health care professionals knowledge/attitudes and beliefs about palliative care; and
- Consider providing education and tools regarding end of life care and specialized populations such as persons with mental health issues, aboriginal population etc.

Supporting Quality Palliative Care in Communities

Concentration on making a shift to an upstream approach to palliative care so that death does not come as a surprise for patients and their families. Communication and planning begins early in the diagnosis in order to improve quality of life, life expectancy and patient/family experience.

Target populations:

- Persons with a palliative diagnosis who would benefit from palliative and EOL care:
 - Palliative approach in residential care.
 - Palliative approach in chronic disease.
 - 10-20% of palliative patients requiring consultation for complex symptom management.

NH will support quality palliative care in communities by:

- Expanding the awareness of the PC Consultation Team for complex symptom management and the availability of the physician on call/consultation service.
- Embedding the idea of palliative care occurring in all care settings. This will be a shift to an understanding of the palliative approach along with symptom management skills in all care settings.
- Improving palliative care planning and management of palliative transitions.
- The further implementation of the physician End of Life Practice Support Program will help assist with these transitions by including integrated professional teams.
- Identifying and addressing needs in rural and remote communities such as access to specialists and home care.
- Addressing PC practice issues to help learning and improvement of patient safety and care.
- Improving weekend/night response and access to PC services acute care admissions or emergency room visits.

Strengthen Health System Accountability and Efficiency

NH has EOL care services that reflect evidence based, clinically appropriate practice. NH needs to ensure the continuation of this practice by continuing to improve processes and efficiency.

Target populations:

- Public/communities
- Health care providers

NH will continue to:

- Create clinical guidelines, protocols and standards, will focus on clinical transitions and interdisciplinary care to improve pain and symptom management, based on an evidence best practice.
- Improve access to services and supplies by streamlining of policy and administrative processes and participate in provincial initiatives.
- Integration of the palliative approach into service planning for chronic disease and special populations (aboriginal, mental health and addictions, etc.) and seniors care.
- Work within the primary care model with integrated professional teams to improve transitions and communication.

NH will work to:

- Reduce redundancy in processes such as registration and paperwork;
- Identify inequities in service access and strive to reduce or eliminate the inequities; and
- Continue to participate in provincial initiatives regarding best practices, education and processes and policy.

Designated Palliative Care Beds

Currently, 13 designated palliative care beds are located in a number of Northern Health residential care facilities as a means to improve the quality, access and integration of palliative care for patients who have a palliative designation. Care is provided within the framework of the NH Palliative Care Program. Another 10 beds are located in Rotary Hospice House in Prince George.

Northern Health has committed to an additional 11 designated palliative care beds within the next five years to be located in the most appropriate communities. The beds will be designated to allow flexibility of use to accommodate the changing needs of the rural communities. The focus of the bed placement will be within NH's community hospitals and health centres in the more rural and remote communities that are not large enough to accommodate a stand-alone palliative care facility or do not have capacity in their residential care facilities for additional beds. The addition of these designated beds will allow patients to remain in their home communities and provide the correct palliative care services they need if they cannot be looked after in their homes. The emphasis regarding the designated palliative care beds will be on increasing utilization.

Priority Actions

The Role of Northern Health	Priority Actions		
Provision of Palliative Care and End of Life Information, Education and Tools	Year 1-2	Year 3-5	Ongoing
<p>Work with communities to increase public awareness of palliative care and end of life approach</p>	<ul style="list-style-type: none"> • Social marketing and promotion involving a communication strategy in collaboration with provincial and community partners such as BC Center for Palliative Care and hospice societies. This communication strategy would be basic information on what palliative and end of life care is 	<ul style="list-style-type: none"> • Continuing communication strategy expanding on basic information shared in year 1-2 	<ul style="list-style-type: none"> • Updating, maintenance and continued development of website • Collaborate on campaigns with provincial and community partners • Participate in health fairs and other relevant activities • Active promotion of advanced care planning
<p>Education</p>	<ul style="list-style-type: none"> • Palliative Care Consultants partner with inter professional teams to ensure teams are equipped to promote and provide palliative and end of life care • Increase opportunities for collaboration between NH and community partners such as hospice societies for education • General overview of palliative care included in the NH learning management system 	<ul style="list-style-type: none"> • Expand education and tools to serve specialized populations • Increase education opportunities for volunteers 	<ul style="list-style-type: none"> • GPSC End of Life Care Practice Support module education to all interested stakeholders (supported by the Regional PC Consultation Team) • Weekly education by Palliative Care Consultants • <i>Monthly Hot Tip</i> • Face to face education when requested either with staff or patient and family • Standardized orientation materials
Supporting Quality Palliative Care in Communities	Year 1-2	Year 3-5	Ongoing
<p>Service Delivery</p>	<ul style="list-style-type: none"> • Palliative care services to be provided in all care settings, service providers and stakeholders to use education and skills to feel comfortable with the service • Delivery of excellent symptom management across all care settings • Develop a process for planning and management of palliative and end of life care transitions 	<ul style="list-style-type: none"> • Expand availability of physician on call services including development of telehealth • Expand consultative services • Address issues for rural communities • Expand response and access to palliative and end of life care for weekends and nights (acute care, residential and community staff level of comfort and availability) 	<ul style="list-style-type: none"> • Coaching by Palliative Care Consultants for staff, patients and family

	<ul style="list-style-type: none"> Identifying issues for rural and remote communities and specialized populations 	<ul style="list-style-type: none"> for this to happen) Exploring and developing utilization of volunteers more robustly for support for patients and families in all settings 	
Strengthen Health System Accountability and Efficiency	Year 1-2	Year 3-5	Ongoing
Work Flow	<ul style="list-style-type: none"> Develop plan to improve pain and symptom management that can be delivered by all care providers including inter professional teams 	<ul style="list-style-type: none"> Integration of the palliative approach into service planning for chronic disease and special populations 	<ul style="list-style-type: none"> Create new and relevant clinical guidelines, protocols and standards
Administrative Processes	<ul style="list-style-type: none"> Participation in provincial LEAN initiatives for Provincial Palliative Benefits Forum within each HSDA for discussion and decision making for palliative and end of life care through mechanisms such as advisory committees 	<ul style="list-style-type: none"> Streamlining of policy and administrative processes 	<ul style="list-style-type: none"> Participate in provincial initiatives and invite stakeholders when appropriate
Service Delivery	<ul style="list-style-type: none"> Provincial initiatives under BC Centre for Palliative Care - (includes projects to standardize palliative care education for health care providers, and standardizing resources) 	<ul style="list-style-type: none"> Identify inequities in service provision and move towards changing service delivery to eliminate inequities 	
Designated Palliative Care Beds	Year 1-2	Year 3-5	Ongoing
Increase Designated Palliative Care Beds	<ul style="list-style-type: none"> Increase designated beds in community and acute care by 11 beds with an emphasis on rural and remote settings 	<ul style="list-style-type: none"> Monitor and evaluate the need for designated palliative care services at University Hospital or Northern British Columbia (UHNBC) for people receiving radiation and other treatments for palliation (need to monitor to ensure that sufficient, appropriate PC support services are available to this population) 	<ul style="list-style-type: none"> Monitor bed utilization

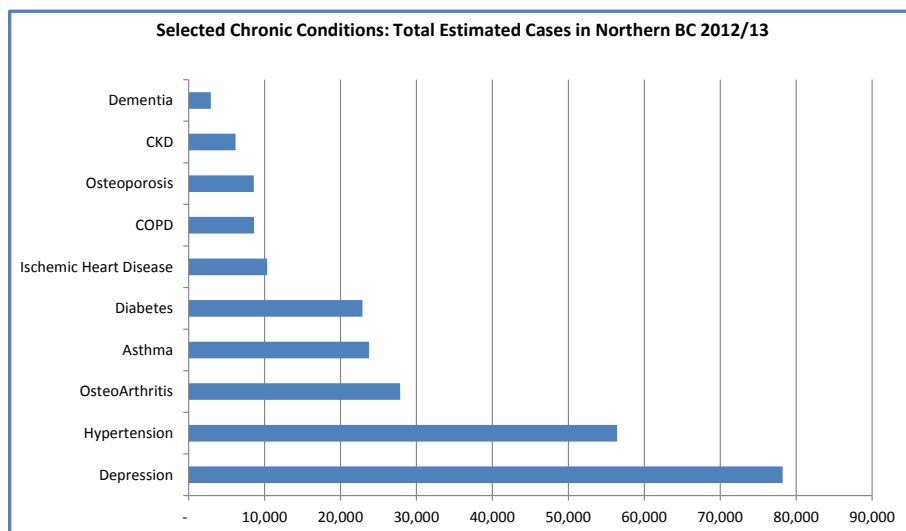
Appendix 1 - Rising Burdens

A Rising Burden of Chronic Disease- Palliative Approach

Chronic diseases are prolonged conditions that may be terminal and eventually end someone's life. These conditions include diabetes, heart failure and other heart disease, chronic obstructive pulmonary disease, kidney disease, and dementia. People with chronic conditions represent approximately 34 per cent of the B.C. population and consume approximately 80 per cent of the combined physician payment, PharmaCare and acute (hospital) care budgets (DAD, n.d.). The success of our health care system has created a situation in which we now manage chronic diseases longer and more effectively than we ever did before. Because of advances in medical technologies, it is not unusual for a person to live long enough to develop multiple chronic, deteriorating conditions. In fact, almost 4 out of 5 people over the age of 65 have one chronic disease and about 70% have two or more progressive, life-limiting conditions (BC Ministry of Health, 2007).

The evidence shows that once these chronic conditions are diagnosed, taking a palliative approach not only helps improve quality of life through symptom management, it has also been shown to increase life expectancy (Canadian Hospice Palliative Care Association, 2015). The evidence also shows that there are opportunities to better manage these conditions and to improve outcomes through integrated approaches that include patient self-management strategies and an integrated, interdisciplinary team support with specialist involvement when necessary.

During 2012/13 there were an estimated 20,541 newly diagnosed cases related to chronic illness among northern residents (BC Ministry of Health, 2010). The graph below shows the relative proportions for the most common conditions that may require palliative approach or care. Combined, these conditions constitute an enormous burden on the population of northern British Columbia and on its health service system.



From NH 2014/15

Detailed Service and Operational Working Papers . The British Columbia Ministry of Health provides a comprehensive analysis of health system populations and services known as the Health System Matrix. Using 2012/13 data, this matrix demonstrates that persons with mild, medium and highly complex chronic conditions draw deeply and widely on health services provided by NH and other providers

A Rising Burden of Frailty and Dementia - Palliative Approach

Taking a palliative approach with persons with frailty and dementia will significantly impact on the NH Palliative Care Strategy moving forward, as these numbers are expected to rise. Frailty is a general term reflecting weakness, susceptibility to illness, injury, and prolonged recovery times. Elderly frail individuals are often the highest users of healthcare services; when in care they face significant risk of developing infections and depression, experiencing falls and have a poorer prognosis. Dementia is a condition where cognitive ability declines in a manner beyond that associated with normal aging. Dementia most frequently occurs in those aged 75 years and above. Individuals with dementia often need a variety of supports; either at home or in conjunction with residential care (Northern Health, 2014).

The table below provides the 2013 population for northern British Columbia aged 75+ along with a projection to 2023. Beside the overall 75+ population are estimates of the number of individuals in the North above 75 years of age who may be considered frail and those with mild, moderate and severe dementias. Estimates of frailty are made based on assessments and use of services such as non-acute home nursing and support, residential care, and assisted living supports. Dementia is estimated using the Cognitive Performance Scale (CPS) which is part of the assessment for home care and residential care services. Projecting existing estimates of frailty (approximately 10 per cent of the 75+ population) and moderate and severe dementia (approximately 6.3 per cent of the 75+ population) forward to 2023, it can be anticipated that NH will see an increase in the order of 50 per cent in the number of individuals who are frail and/or experience dementia (moderate and severe) over the next ten years. This increase threatens to place a significant burden on primary, acute and long-term care health services unless new ways of managing dementia and/or serving individuals with dementia can be found (Northern Health, 2014).

Year	Population 75+	Frailty		CPS 2: Mild		CPS 3-4: Moderate		CPS 5-6: Severe	
	P.E.O.P.L.E. 2012	#	% of Pop	#	% of Pop	#	% of Pop	#	% of Pop
2013	14,307	1430	10.0%	440	3.1%	606	4.2%	300	2.1%
2023	23,317	2331	10.0%	717	3.1%	988	4.2%	489	2.1%

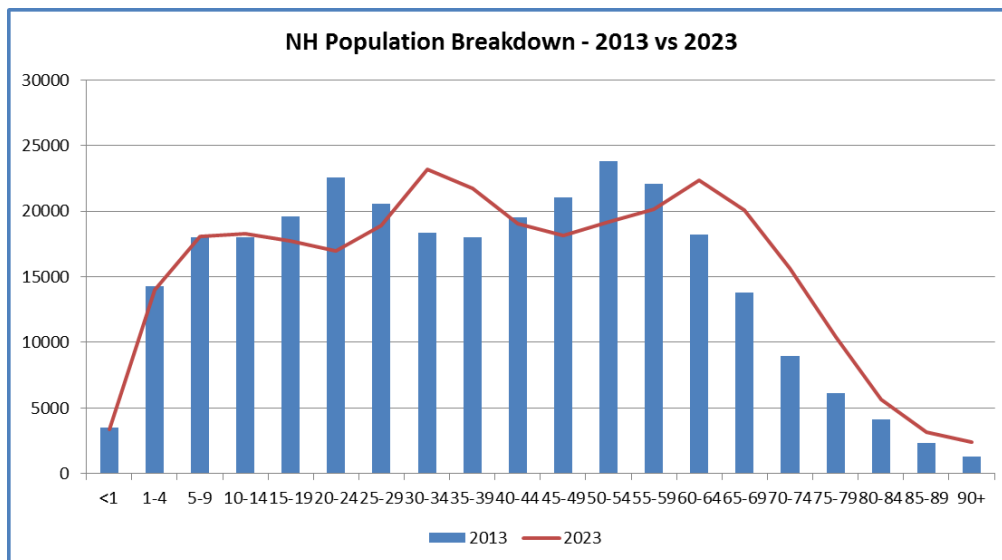
Sources: Northern Health HCC 2014, MOHS Health System Matrix 5.0

Note: -This is a straight line projection

-The frailty figure (from the Health System Matrix 5.0) does not capture all those whom we have identified as having dementia. Likewise, it does not count individuals who may be case managed, but choose to purchase their own services (the community segment captures "People who are living in publicly funded Assisted Living units or living in their own homes receiving publicly funded home support.")

Population Changing and Seniors Increasing – Increased need for Palliative Approach

While the British Columbia population is experiencing significant growth overall, the total population of northern British Columbia is not expected to increase dramatically over the next 15 years. Between 2013 and 2027 the total population is expected to increase by just 6.4 per cent (from 294,188 to 313,121), averaging to 0.4 per cent per year. An aggregate analysis reveals a rising challenge facing NH: A rapidly aging population, bringing with it a variety of health challenges including frailty, chronic disease and dementia (Northern Health, 2014). These first two population groups can be seen in the chart below for the years 2013 and 2023.



From NH 2014/15 Detailed Service and Operational Working Papers, Source: BC Stats Population Projections September 2012 edition.

British Columbia’s elderly population is the fastest growing in Canada. Within the next 10 years there will be fewer school age children than people over 65, and more people retiring than entering the workforce. The aging population is a significant driver of demand since the need for services rises dramatically with age.

NH will be significantly challenged by the upcoming growth of the northern British Columbia seniors’ population. Although the percentage of seniors in the region’s general population is currently the smallest of all the health regions (approximately 10 per cent), the seniors’ population is expected to grow quickly over the next 15 years from 2013 to 2027. During this period, both the 65+ and the 75+ populations are expected to grow by over 78 per cent and 91 per cent respectively. These are the highest growth rates of all the health authorities and effectively represent a near doubling of these populations by 2027(Northern Health, 2014). While many elderly British Columbians enjoy good health, aging continues to be associated with a variety of complex health challenges necessitating a wide range of health services and family supports from acute through to palliative care. A rising burden of chronic disease, frailty and dementia are three of these age related challenges that will drive a significant demand for health services.

Health Authority	Estimated pop. aged 65 and over 2014	Projected pop. aged 65 and over 2020	% change
Interior	158,342	189,817	20%
Fraser	247,721	319,177	29%
Vancouver Coastal	177,432	225,440	27%
Vancouver Island	164,582	206,499	25%
Northern	37,000	48,739	32%
BC	785,077	989,672	26%

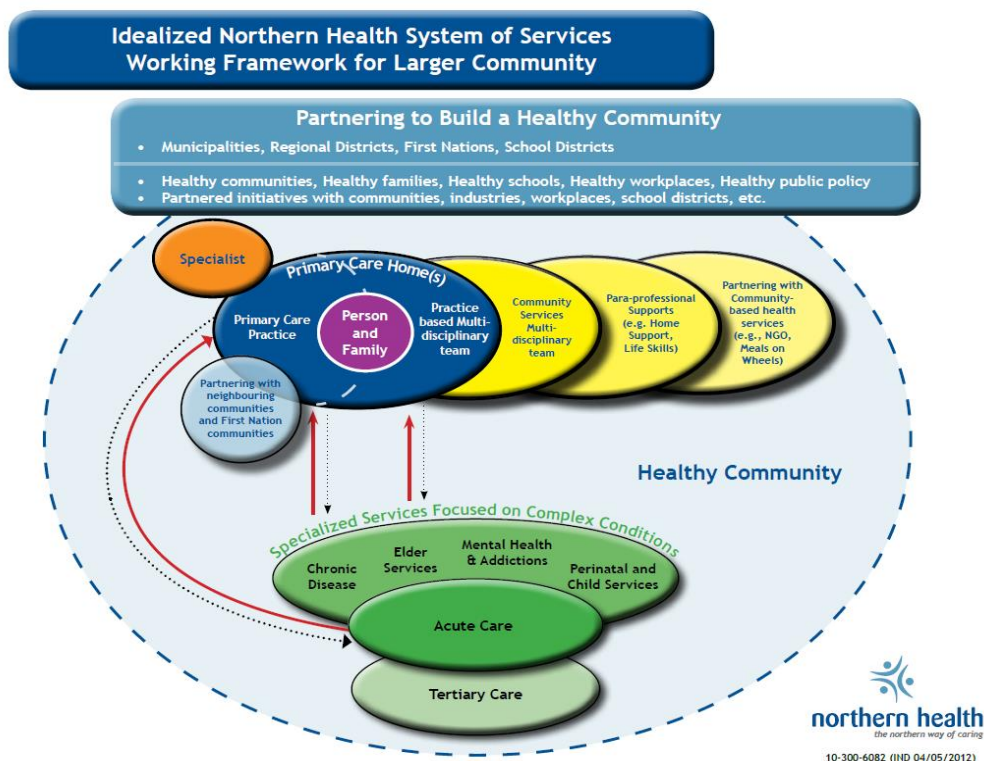
Table 8 Projected percentage increase population aged 65 and over, 2014-2020

Appendix 2 - Idealized Northern Health System of Services Framework

The idealized systems are actions prioritized by NH based on analysis consistent with the Ministry of Health’s required Detailed Service and Operational Working Papers. NH’s vision has the person and family at the centre, situated within a multi-disciplinary primary care home. Teams will be established to “wrap around” the primary care home in order to serve patients better. Particular attention will be given to ensuring that appropriate team services are available for those who need them most: people with complex, chronic diseases, frailty, mental health & addictions problems and moms/families with babies. The following conceptual diagram has been helpful in describing/discussion our vision within and outside of NH.

Key attributes of Northern Health’s idealized system include:

- Physicians as critical cornerstone to the patient centred primary care home (PCH). Supports are put in place to fortify the primary care home in collaboration with physicians. A key focus of the PCH is the longitudinal coordination of the person’s care
- Multi-disciplinary teams wrapped around primary care home provide support as required. Communication and consistent care planning among the team is essential
- Realignment of community services to reduce barriers and support team based care. A key focus is placed on determining what within the existing service lines of Mental Health & Addictions, Public Health, Chronic Disease Management and Home & Community Care are truly specialized and what aspects can be realigned toward the primary care home and supporting teams. (Northern Health, 2014)



Appendix 3 - Principles of the Northern Health Palliative Care Program Framework of Care

Unit of Care - Patient and Families - Person and Family Centered Care

Northern Health palliative care places the person and family at the center of care, and recognizes the unit of care to be both the patient and family as defined below:

Patient: “The person living with an acute, chronic, or advanced illness. The term patient, as opposed to client, is used in recognition of the individual’s potential vulnerability at any time during the illness.” *Family*: “Those closest to the patient in knowledge, care and affection. These may include the biological family, the family of acquisition (related by marriage/contract) or the family of choice and friends (including pets). The patient identifies who will be involved in his/her care and /or be present at the bedside” (CHPCA, 2002).

Patients and families have the responsibility for and will be supported to:

- When ready, engage in pre-planning for end of life care and issues e.g. choose a preferred place of care and death, consider an advanced directive, attend to legal / will issues, make funeral arrangements and inform their healthcare team of decisions;
- Ask questions (if they wish to know) until they clearly understand their health condition, treatments or method of care;
- Tell the interdisciplinary health care team when they are experiencing pain, other symptoms or have concerns / questions.

Primary Care Providers: Family Physicians and Nurse Practitioners (NP)

Family physicians and nurse practitioners are primary care providers, but have a unique role on the team.

In addition to the primary care provider responsibilities listed below, the family physician and NP will:

- Initiate the End of life (EOL) Practice Support Program (PSP) module/algorithm in the primary care home; this includes taking the lead with decision making and advanced care planning. Discuss resuscitation issues and choices with the patient and family, sign the No CPR form and obtain signatures from the patient or Designated Decision Maker as appropriate;
- Confirm by signing the Palliative Care Registration form, that the patient meets the PC program criteria. (see registration criteria)
- Register the patient with BC Palliative Care Benefits as appropriate (registration form);
- Request provision of home care services as early as possible in the palliative process;
- Maintain the responsibility for the day-to-day medical management of the palliative patient in all care settings, which may include home visits;
- Ensure care plans are in place for predictable challenges at end of life including appropriate medications and supplies in discussion with the home care nurse.

For an expected death at home ([planned home death resources](#))

- Discuss arrangements for actions at the time of death with patient, family and home care nursing;
- Complete *Expected Death at Home* form as per *Joint Protocol for Expected/Planned Home Death* policy.

Primary Care Providers - Interprofessional teams will work with the primary care home to:

- Provide early identification of patients who meet palliative care status;
- Assist with the transitions identified in the EOL PSP module/algorithm;
- Provide ongoing assessment of palliative care patients and their families using standardized and validated assessment tools ([See Standardized Assessment Tool Policy DST](#));
- Provide timely pain and symptom management based on approved [clinical guidelines](#);
- Collaborate and communicate with other primary care providers to ensure the needs and expectations of the patient and family have been addressed;
- Participate in local palliative care interdisciplinary teams and work collaboratively with the interdisciplinary primary care providers;
- Develop, plan, and evaluate individual care plans while acknowledging the diversity of individuals and of services available in communities within each Health Service Delivery Area;
- Request consultation with members of the Palliative Care Consultation Team as needed ([See Consultation Request Procedure DST](#));
- Assure continuity of care across the continuum and within each health care setting using detailed discharge planning and information sharing;
- Provide teaching and support to assist the patient and family in making informed decisions about care options that are based on ethical principles;
- Educate family members/informal caregivers about how to provide care and comfort measures for the patient and for themselves;
- Provide or refer to bereavement support services.

Primary Care Consultant Team

Consultants as a specialized level of service will:

- Be an advocate for the NH Palliative Care Program and strategy;
- Provide education, support and mentorship to build capacity among primary health care providers, the PC Consultation Team, colleagues, residents and students;
- Provide consultation and clinical expertise for primary care providers in all care settings;
- Participate in program development at the regional and local level;
- Help to establish and promote an interdisciplinary approach to care by participating in and/or promoting the activities of the local PC clinical rounds and the HSDA PC Operational Advisory Committee;
- Be responsible for statistical data as required and for the maintenance of the PC Registry in each HSDA and the collection of data ([See Registration Policy DST](#); [Statistic Procedure DST](#));
- Identify situations in which clinical care does not meet acceptable standards, despite consultative support provided, and reports through the appropriate channel;
- Collaborate with non-NH caregivers (e.g. volunteers);
- Participate in research and evaluation activities

Appendix 4 - How does the Northern Health Palliative Care Program Work?

Registration Based

To access identified palliative care services a patient must be registered with the NH PC Program ([Registration Policy DST](#)). Registration may be initiated by any healthcare provider but requires written confirmation by a physician.

The purpose of registration is to:

- Support earlier identification of palliative patients resulting in more appropriately coordinated care and timely access to services and symptom management.
- Provide quantitative data in order to direct future program development.

Criteria for registration with the NH Palliative Care Program:

- The patient is living with a life limiting or progressive illness.
- Curative treatment is not the primary focus of care, rather the focus of care is on comfort and symptom management.
- The patient, or their representative / health care decision maker, has agreed to accept palliative care services.
- The patient has a life expectancy of less than 6 months.
- A physician has confirmed the patient's status to be palliative.

Palliative Care Registry

A registry of all patients identified as having met the criteria for palliative status will be maintained.

The NH Palliative Care Registry is maintained to:

- Provide a central database of all patients designated as palliative in Northern Health.
- Confirm patient eligibility for select supplies, services and equipment at no daily charge.
- Provide quantitative data in order to monitor current program activity and direct future program development.

The PC Consultation Team will be responsible for entering and updating client information from the NH PC Registration Form. ([Registration Procedure DST](#))

Data will be collected at the local, HSDA and regional level in order to monitor, evaluate and improve palliative care clinical outcomes and services. The data will be collected primarily from the PC Registry of patients.

Health Service Delivery Area Palliative Care Advisory Committees

- Monitor outcomes and deliverables for palliative care specific to the Health Service Delivery Area.
- Provide a venue to identify gaps in palliative care service delivery and identify and implement solutions.
- Promote collaboration, communication and integration among providers of palliative care services in the Health Service Delivery Area.
- To identify educational needs and planning of education delivery.

- Work collaboratively with the PC Consultation Team in the development of best practice resources and education related to palliative care.
- Provide a venue for care providers to raise issues and concerns regarding palliative care
- Chaired by the Health Services Administrator. Membership consists of Northern Health staff and external partners and stakeholders in palliative care.

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