Community Model of Palliative Care

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WRHA Palliative Care Program

- Integrated program across the spectrum of care settings (home, long term care, acute care), ages, diagnoses

- Each patient is assigned a Coordinator, based on their location in Winnipeg

- Program clinical staff comprised of Palliative Care Coordinator, Palliative Care Community Nurses, Palliative Care Clinical Nurse Specialists, Palliative Care Physicians, Palliative Care Psychosocial Support Specialist

- Goal is to support patients and their families in their preferred care setting, addressing their needs through the most appropriate utilization of resources
WRHA Palliative Care Program: Potential Gaps in Service Provision

- Transitioning between care settings (e.g. acute care to home, home to PCH) risks fragmentation of care

- Support of patients at home is often “reactive”, where home visits are done in response to a problem rather than “proactive”, where problems are preempted

- In contrast, patients on a hospital ward are seen routinely, in order to identify problems early and prevent their escalation

- In the community there is most commonly a single discipline (nursing) involved in the bulk of home support, while on a palliative care hospital ward, staff meet daily to review patients as an interprofessional team
Virtual Ward Model

• Designed to promote an Inter-professional team approach to care in the community to mirror the approach to care provided in acute care units

• Team meets and decides on prioritization of visits, sharing workload (new consults and follow-up visits)... the entire geographic area is considered a “ward”, and patients being followed are its “inpatients”

• The same clinical team follows the patient through all care settings in that area (home, acute care, long term care), providing continuity of care

• Health care providers in primary care, long term care and acute care are supported by a consistent group of palliative care clinicians, fostering development of collegial relationships and helping build capacity through modeling of clinical practice and through education
Community Teams:
• Community Nurses
• CNS
• MD
• Coordinator
• Psychosocial
Pilot Project

Pilot project conducted in Northeast area of WRHA

- Feedback from community nurses
  - Felt more supported and connected to inter-professional team
  - Felt more confident at supporting families to stay at home longer
  - More proactive planning being done
Feedback from Northeast Project

• Palliative Care Coordinator
  – Admissions to Palliative Care Unit or acute care have been prevented
  – Transfer requests for Palliative Care Units from Concordia and Seven Oaks have decreased as a result of support from Palliative Care CNS and Physician
  – Clients and families are satisfied with care
Feedback from Northeast Project

- Palliative Care Physician
  - Follow-up visits are important for patients and families
  - Better understanding of care provided in community
  - Team approach is vital to keeping patients in community
What we have learned

• Frequent communication between team members is essential
  – Team members need to check in with each other in the morning to prioritize visits/consults, share workload, discuss clinical issues and share information

• Following up on visits/consults is essential
• Community team needs to be able to be responsive to urgent calls
What we have learned

• Scheduling home visits/consults using Outlook has worked well
  – Team members need access to calendars
  – Those with mobile devices can see appointments while out in community

• Regular team meetings to discuss clinical issues and team functioning are essential – operationalizing is challenging

• Utilization of scarce psycho-social resources
What we have learned

• Communication on transition between care settings is still challenging

• Opportunities to further support community nursing practice through joint visits with inter-professional team
What is Next?

• Expand model to rest of Region
• Develop evaluation framework
  – Working with Manitoba Palliative Care Research Unit
• Continue to develop processes and tools
• Improve collaboration with primary care providers and specialty clinics
  – Promote model where consults by community palliative team can be conducted in primary care and specialty care clinics